Introduction

He started yelling…and he just got me into a state...
I couldn't walk, I was paralysed, I couldn't hold my
head up, I was in tears and he said, 'I'm taking you
to the doctor, you're mentally ill. You're either having
an affair or you're mentally ill. They're the only two
conclusions I can come to why you're doing this.' I
can't be that bad, I've changed. (Head & Taft 1995)

It can be absolutely anytime, anywhere. It's just
certain things trigger off a flashback. And if I have a
flashback then they always follow with a panic attack.
(Elaine, whose husband was charged with attempted
murder) (Humphreys & Thiara 2003, p. 215)

I was once put under a Community Psychiatric
Nurse...by my doctor and again I had bruising on
me. When I showed the bruising…he said to me,
'I don't know...personally I don't think you need
psychiatric treatment. You need to see a marriage
guidance counsellor.' (Myra) (Humphreys & Thiara
2003, p. 216)

Intimate partner abuse, also known as domestic
violence, is an abuse of power. The Australian
Medical Association (1998) defines it as the
domination, coercion, intimidation and victimisation
of one person by another by physical, sexual, or
emotional means within intimate relationships.
The World Health Organisation’s (WHO) Report on
Violence and Health (2002) highlighted violence,
including partner abuse, as a serious global public
health problem causing grave health damage to
individual people, communities and countries. It
found that women are the overwhelming majority of
partner abuse victims.

The Australian Bureau of Statistics found that one
in four or five Australian women (23%) reported
experiencing abuse from partners during their
adulthood. The rate was higher (42%) among
separated or divorced women when compared with
the rate (8%) among currently partnered women.
Within the last twelve months, 2.6 per cent of
women had experienced physical or sexual abuse
although women aged between 18 to 24 (7.3%)
experienced more abuse from male partners than

Victimised women seek help from health services
more often than women in the general community,
but most do not disclose. Shame, self-blame, fear
and other barriers, some within the health services
themselves, commonly prevent them. The majority
of victims are never asked about it by their health
service providers (Hegarty & Taft 2001).

While many people define partner abuse by the
acts of physical or sexual abuse perpetrated against
victims, women victims/survivors have argued
that the psychological effects of abuse are more
profoundly damaging to their sense of self than
any physical injuries. Physical injuries heal more
quickly. As the quotes above illustrate, the damage
to women’s mental health by partner violence
can be severe. In addition, the response by health
services, including mental health services, can often
be uninformed and inappropriate. At worst, these
services can re-traumatise, re-victimise, stigmatise
or be unwittingly drawn in to the abuser’s web of
control, further harming the woman’s emotional self:

They put me in a different room and him and his
doctor talked and they organised it...She has got
This Issues Paper draws on the most recent evidence to explore the impact of intimate partner abuse on women's mental health. It discusses our evolving understanding of women's mental health disorders, from the earliest theories of their origin in women's innate physiological - especially reproductive - weaknesses, to the important role of factors at all levels from the individual person who abuses to factors within societies, including the social construction of gender. It outlines the prevalence and patterns of intimate violence-related mental health disorders among women in Australia and globally, finding that these exhibit remarkable similarities irrespective of country and culture. The evidence points to the co-existence of mental disorders amongst abused women, such as post-traumatic stress disorder* and substance misuse. It also highlights that the greater the frequency and severity of intimate partner abuse, the greater the harm to a woman's mental health. Similarly, the further from the abuse experience a woman is, the greater the reduction in her symptomatology.

The paper then moves to a discussion of violence against women and its broader ecology, i.e. the wider social and environmental context. This includes an exploration of how factors such as poverty, unemployment, low education, wider social conflict, subsequent immigration and refugee status, can exacerbate the effects of intimate violence on mental disorders. Further, an ecological perspective shows how abuse can lead to homelessness which itself may aggravate a spiral into more serious illness. It is argued that understanding intimate partner abuse within a framework of the social ecology* of health, is critical to understanding the impact of the wider context on options a woman may have to change her situation and the choices which she may make. Such understandings are essential if health care providers are to help her.

The paper also discusses the contributions of theories of social status and the role of humiliation, entrapment and coercion in explaining the effects of intimate violence and abuse on women's mental health. It is argued that conservative psychiatric diagnoses provide an inadequate framework through which the needs of abused women have been interpreted and that institutional inertia has sometimes contributed to women's further harm.

The paper concludes by arguing that we can promote women's mental health, through tackling the damage caused by partner abuse at all levels of society. It outlines the paradigm shifts required in health system responses to abused women and explores the role of primary and acute mental health services. Finally it discusses what mental health promotion might mean both within the mental health system and in the wider community.

The quotes used throughout the paper are drawn from a 1995 study of the experiences of abused Victorian women with their primary health care services and a recent UK study of mental health services and domestic violence (Head & Taft 1995; Humphreys & Thiara 2003). A glossary of terms is included at page 21. Terms defined in the glossary are indicated thus* in the text.

The evolution of understanding about gender, partner violence and women's mental health

This section takes an abbreviated journey through understandings over time of mental illness in women and girls. It reveals the invisibility and unimportance of the role which partner violence was thought to play until relatively recent times. Once it was perceived, an understanding of the complex inter-relationship between mental ill health and partner abuse evolved much further. It shifted from a belief that individual psychopathology* was the root problem to an emphasis on family dysfunction or poverty and expanded more recently to include the role played by gender.

For centuries, women have been considered ‘prone’ to mental illness. Women's human nature was for years considered biologically given, unmediated by culture or how culture fashioned the distinctive features of a ‘feminine’ personality. A wide range of psychopathologies was ascribed to women's nature and biology, arising from the distorted dualism of sex-role stereotyping, the common ascribing of personality disorders* in women to their problematic reproductive functions, and masculine bias (Astbury 1996). Male partners were thought of as having little or no relevance to this, merely to suffer its consequences and to have legal responsibility for women's care. In the very earliest legal codes, women were held responsible and punished if male partners physically harmed or sexually defiled them. Battered women were the legal property of men, who had a right to punish their ‘disobedience’ and they were thought either to have provoked or deserved their beatings. This is still the case in some countries (Oyekanmi 2000).

One of the early ‘scientific’ theories, superseding much earlier religious explanations for women’s ‘madness’ as evil or possession by the devil, was ‘hysteria’, derived from the Greek word for the womb. Many physicians thought that hysteria was a woman's disease and originated in the uterus (womb). Early scientists, the most famous of whom...
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was Charcot in the late 19th century, certainly believed this. Charcot taught about hysteria in open medical lecture theatres, using young female patients from the Paris asylums, who were often victims of violent and exploited lives. Considered a pioneer in his field, Charcot carefully documented and classified the symptoms of hysteria, which he called ‘the Great Neurosis’. He illustrated the variety of hysterical symptoms, for example, paralysis or convulsions, to galleries of fascinated onlookers either through stimulation (such as touching victims in sensitive places) or hypnosis (Herman 1992, p.10). One of the brilliant young observers in Charcot's lectures was a budding scientist, Sigmund Freud, who sought to find the origin of hysteria.

Freud is the father of psychoanalysis and his discovery of the role of the unconscious is revolutionary. The understanding of women's mental health was also powerfully framed by the work of Freud. Freud's early work on hysteria is still thought by some to be empathic and revelatory. After listening to his female patients talking about rape and sexual abuse in childhood, he wrote eloquently and compassionately about the traumas associated with sexual abuse in The Aetiology (origin) of Hysteria’ (Herman 1992). However, following the criticism and furore the paper produced in conservative 19th century Vienna, he revised his theory that hysteria was caused by sexual abuse. Instead, he theorised that hysteria's aetiology was women's repressed sexual fantasies. This came to have a sustained and damaging influence on diagnoses of women's mental health and on belief in women's truth telling and their treatment. Hence, Herman argues that psychoanalysis, the dominant psychological theory of the 20th century, pioneered by Freud, was ‘founded in the denial of women's reality’ (Herman 1992, p.14).

I cut myself because I had to be punished because nobody had believed me. And so I blamed myself (Carol, a woman abused both as a child and an adult) (Head & Taft 1995).

The work of Helene Deutsch, a neo-Freudian psychiatrist, contributed to the development of concepts of women’s ‘masochism’ in western science. In the 1920s, Deutsch theorised about the connections between women’s bodies and minds in pregnancy and childbirth. Influenced by Freud’s view about women’s desire for children as stemming from ‘penis envy’, Deutsch described the physical symptoms of pregnancy as originating in unresolved childhood conflict. She once described childbirth for women as an ‘orgy of masochistic pleasure’. Astbury (1996) argues that the views of Freud and Deutsch influenced professional understanding about why women suffered from postnatal depression and other postpartum disorders. Psychoanalyst Karen Horney, a contemporary of Freud and Deutsch, challenged these views of what may influence postnatal depression, but her views were not published and she was ostracised for challenging the orthodox Freudian view that such depression originated in ‘penis envy’ and ‘masochism’ (Astbury 1996). Although we are now aware of the prevalence of partner violence during pregnancy and after childbirth, there is little research to shed light on the independent contribution this makes to postnatal depression (Taft 2002).

Evolving from the growing Western science of psychology, theories of women’s masochism and other innate individual mental inadequacies developed further. These inadequacies were considered by many mental health professionals to be the causes of intimate partner abuse. Victims who were repeatedly harmed were, and still may be thought by some health professionals, psychologically to ‘need’ the abuse (Walker 1984).

In the early sixties, researchers who did not succeed in gaining the cooperation of male perpetrators of abuse, in order to study them, redirected their attention to their more cooperative female partners. This resulted in a study called ‘The Wife-Beater’s Wife’. This study concluded that battering fulfilled these ‘feminist’, ‘passive’, ‘castrating’ or ‘masochistic’ women’s needs (Herman 1992, p.117). In a more recent echo of these damning descriptions, as recently as 1988, a study of US Emergency Department responses found labels in abused women’s medical records including ‘crock’, ‘hysteric’, ‘neurotic female’ and ‘hypochondriac’. The researchers also noted the inappropriate prescription of major and minor tranquillisers and sedatives to women who may be unsafe or suicidal, without offering them other forms of support (Kurz & Stark 1988).

In the late 1970s (the era of the second wave of the Women’s Movement), Walker (1979) wrote a now classic study of battered women, which located the problem of abused women’s health disorders with their abusive partners. She adapted Seligman’s theory of ‘learned helplessness’ to explain the decisions and actions of battered women. She noted that women were so repeatedly defeated by their partners’ violence and control, that they exhibited symptoms of helplessness, returning in defeat to their stalking, harassing partners, symptoms which
were mistaken for masochism (Walker 1979). She was later to expand this theory into the ‘battered women’s syndrome’ which was often used as a legal defence for those women who finally murdered their abusive tormentors (Walker 1983). The ‘learned helplessness’ theory has subsequently been criticised, based on findings from studies which highlight the failure of services to effectively assist women, the many ways in which women seek to find effective help to escape violence and the role of positive help-seeking in reinforcing women’s sense of their own competency (Gondolf & Fisher 1988; Levendovsky et al. 2000). Although Walker’s study was revolutionary at the time in highlighting the role and responsibility of the perpetrator of the abuse, her theory did not take sufficient account of the evidence of women’s agency and the barriers constructed from institutional inertia.

Concurrently with new views about violence against women arising from the Women’s Movement, in the field of mental health in the late 1970s, the role of social factors (rather than biological, hormonal or reproductive factors) in women’s mental health disorders, especially depression, was given greater prominence. In their pioneering work, Brown and Harris (1978) surveyed the rates and reasons for depression among women in disadvantaged areas of London. As well as poverty, they emphasised the role of social factors, such as unemployment, significant severe stressful life events and a ‘non-confiding’ marriage in contributing to women’s mental distress.

In the late 70s and early 80s, the nature of marriage and the couple was given prominence in the work of family and conflict theorists, such as Straus and Gelles (1986), who sought to explain and describe violence in families. Straus conducted what are now ground-breaking but controversial population studies of cohabiting couples in America, using the tool he devised to measure physical partner abuse, the Conflict Tactics Scale or CTS (Straus et al. 1996). The work of Straus and Gelles was pioneering in uncovering family violence, describing the high prevalence of violent acts between partners and of parents towards children. The CTS has been criticised however, as it did not measure the critical aspect of domestic violence – coercion or control. Neither did it measure motivation for violent acts (such as control or self-defence), sexual or emotional abuse or other acts common in partner abuse, such as strangling. Consequently, finding that men and women were equally violent using this tool (irrespective of the frequency or severity of control and domination), they located the problem in the dynamics between the adult partners in the family. In these early gender-blind analyses, men and women were considered equal partners and equally responsible for what was occurring within the family, including any abuse of the children, a major concern at the time (Saunders 1988; Taft et al. 2001).

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Expanding the context beyond the individual to the family was and remains very important. However, there were dissenting theorists. Dutton and Painter (1981) made an early and insightful critique of the existing theories about domestic violence and mental health. They argued that these theories concentrated on factors internal to the woman and hence held the woman responsible both for her victimisation and consequent mental disorder. The factors wrongly emphasised by some family and conflict theorists included:

1. her family history (e.g. her abuse as a child, parental role models and expectations of her role as wife and mother)
2. her personality characteristics and psychological state (such as depression)
3. her lack of access to social or economic resources
4. the dynamics of the relationship (e.g. she demands too much of her partner; she ‘nags’ and he reacts).

Dutton and Painter reframed the patterns of battered women returning to live with the men who abused them as ‘traumatic bonding’. They criticised tendencies in the legal and other systems to describe women as masochistic or to ‘blame the victim’, arguing cogently that such victim-blaming responses served three functions:

1. it protected professionals from recognising that their system did not function efficiently
2. it maintained a belief that the world was just, i.e. people get what they deserve
3. it precluded the necessity to work for system change.

This was ironic, they noted, as it perpetuated the very legal and social climate that contributed to women’s inability to escape the abusive relationship and was thereby creating a self-fulfilling prophecy (Dutton & Painter 1981). They argued that the power imbalance in the relationship, the periodicity of the abuse, the intermittent reinforcement and traumatic bonding between domestic violence victims and perpetrators showed similarities to the
relationships between prisoners of war and hostages to their captors. They proposed ‘traumatic bonding’ as a useful theoretical concept to describe the mental condition of victimised women.

In the late seventies and early eighties, in Australia as overseas, the advent of feminism and the Women’s Movement ‘lifted the lid’ on violence against women in the home (McGregor & Hopkins 1991). Concerned activist women set up safe houses where battered women were given refuge. They offered ‘consciousness raising’ to victims in women’s groups, together with advocacy, legal and financial support. The Women’s Movement called for violence in the home to be recognised as a crime, for men who abused to be prosecuted for criminal acts and for effective sanctions to be developed within the legal system. These radical strategies at individual and systemic levels provided an alternative to the inadequacies of an individualised, medicalised and often unsupportive mental health system. Indeed, the Women’s Movement developed a thorough critique of social, political and medical responses to violence against women in general and in the home in particular (Stark et al. 1979).

This feminist critique drew attention to the long history of support for men’s right to ‘discipline’ their wives. In fact, until 1891, British law permitted a husband to beat his wife as chastisement (McGregor & Hopkins 1991). ‘The notorious ‘rule of thumb’ provided husbands with guidance as to the thickness of a rod that could be used to chastise wives.’ (Murray 2002, p. 85) Despite the sea change in professional and community views of domestic violence brought about by the feminist movement, Dobash and Dobash (1992) have pointed out the persistence of earlier notions in new concepts such as Shainess ‘new female masochism’ (1979) and Norwood’s ‘relationship addiction’ (1991) which they describe as essentially dressing up old theories of masochism and victim-blaming. Explanations of why women didn’t leave an abusive relationship frequently continued to be framed as factors within the women, rather than in the men who abused them and the broader social and economic conditions.

Gradually, as the focus shifted to gender, the responsibility of abusers and other factors such as patriarchy and poverty in relationships, community and society, were separately and together theorised to support men’s use of violence against female partners. Heise, Ellsberg and Gottemoeller (1999, p. 8) proposed an integrated theoretical model (shown below), adapted from Heise (1998, p. 265). This neatly encapsulates the inter-relationships of all these potential influences on why male partners could be motivated to abuse.

Using this model, the World Health Organisation’s 2002 Report on Violence and Health determined how globally, the overwhelming burden of partner violence is borne by women at the hands of men. They describe what contributes to differences in the risk of women being beaten by their male partners between and within countries at all levels of this model. They comment that ‘around the world, the events that trigger violence in abusive relationships

Figure 1: Ecological Model of Factors Associated with Partner Abuse

- Norms granting men control over female behaviour
- Acceptance of violence as a way to resolve conflict
- Notion of masculinity linked to dominance, honor, or aggression
- Rigid gender roles
- Poverty, low socio-economic status, unemployment
- Associating with delinquent peers
- Isolation of women and family
- Marital conflict
- Male control of wealth and decision-making in the family
- Being male
- Witnessing marital violence as a child
- Absent or rejecting father
- Being abused as a child
- Alcohol use

Heise, Ellsberg & Gottemoeller (1999, p. 8), adapted from Heise (1998)
are remarkably consistent. They include disobeying or arguing with the man, questioning him about money or girlfriends, not having food ready on time, not caring adequately for the children or the home, refusing to have sex and the man suspecting the woman of infidelity (World Health Organisation (WHO) 2002, p.95).

In summary, theories about how intimate partner violence affect women’s mental health have shifted profoundly. In the last few centuries, explanations moved from locating responsibility within women’s inadequate biology to their inadequate personalities. They then progressed to a greater awareness of the dynamics within intimate relationships and families, and with the rise of the women’s movement, to the role played by patriarchal dominance and men’s criminal behaviour within the home. These latter perspectives highlighted the role of gender socialisation for both women and men. Many current scholars now argue that in order to maximise recovery for victimised partner abuse sufferers, their trauma should be understood in its broader ecological perspective including the wider impact of forces within the community and society (Herman 1992; Harvey 1996; Stark & Flitcraft 1996; Astbury & Cabral 2000; Riger et al. 2002).

We need to move away from the idea that women have some essentially biologically based proclivity to create their own neurosis* and foment their own misery...this notion of proneness, so eagerly taken up in scientific theories and research, has not produced impartial knowledge at all but rather distorted observations and serious misunderstandings of women's emotional distress...Only with an acknowledgement of the social construction of gender does it become possible to examine the psychological impact of growing up female in a society that historically has defined female as less than fully human. (Astbury 1996, pp. 2, 13)

Violence against women and the global epidemic of mental disorders

Over the last ten years, there has been concern over the growing rate of mental illness around the world, especially depression. An evidence-based review of women’s mental health by WHO devoted an entire chapter to the gendered nature of risk and the impact of violence against women on their mental health. Globally, women suffer more major depression throughout their lifetime than men (Astbury & Cabral 2000). This section surveys the current evidence on comparative rates of depression and other psychosocial illness in women, placing emphasis on post-traumatic stress disorder* or PTSD*. It also examines how and why intimate violence against women results from different and similar origins among women in developed and developing countries, but results in similar mental illness.

...the experience of abuse, endemic or even epidemic on a global scale, has been largely ignored or dismissed by social scientists and psychiatric epidemiologists in studies assessing risk factors for mental disorders. (Fishbach & Herbert 1997, p.1168)

Fishbach and Herbert’s observation about the invisibility of mental health damage from abuse is slowly being challenged, as more and more studies reveal the damage that childhood and adult abuse have on mental wellbeing (Roberts et al. 1998; Read et al. 2003). However, it is important to understand how and why the risk for mental health disorders is gendered. In a recent analysis of world mental health, comparisons between diverse societies and social contexts showed that symptoms of depression and anxiety, unspecified psychiatric disorder and psychological distress are more prevalent among women than men. Depressive disorders comprise 30 per cent of neuropsychiatric disorders among women, but 12.6 per cent among men. Studies of psychiatric disorders across Africa, Asia, the Middle East and Latin America reveal consistent gender differences in the various regions around the world (Desjarlais et al. 1995). However, discovering the relationship between woman abuse and mental health disorders can be very difficult. In some cultures, ‘madness’ could be the only acceptable way for a woman to voice her anger and distress about the injustices in her life; in others, she and her family could be ostracised, as mental illness is a fearful and stigmatising problem.

The boundary between mental (psychiatric) illness and spiritual disorder is complex and contested in many cultures; definition of disease and mental health and wellbeing are not simple to extend across cultures. (Ortiz, 1994 cited in Fishbach & Herbert 1997, p.1168).

The World Report on Violence and Health found lifetime prevalence rates of partner abuse of between 10 per cent and 69 per cent across different countries (World Health Organisation (WHO) 2002). Comparing rates of intimate partner abuse and mental disorders in women across the world is problematic as government agencies and researchers in different countries understand, measure and collect domestic violence data differently and women understand and disclose partner abuse differently (Fishbach & Herbert 1997). Women can disclose differentially, depending on the level of legal protection and cultural shame and sanctions they experience. If, for example, there is no criminal sanction against partner abuse, and separation means poverty and the risk of expulsion from a community, women will be loath to disclose partner abuse, even anonymously. In their international
cross-cultural exploration of partner abuse, Fishbach and Herbert emphasised the different impacts that marital rape, dowry death, exposure to sexually transmissible diseases (STDs) or HIV infection and legal frameworks have on women’s disclosure rates. This illustrated, they argued, the complex cultural meanings surrounding partner abuse (Fishbach & Herbert 1997).

Despite the limitations involved, Golding (1999) conducted a meta-analysis of intimate partner violence studies in order to examine the contribution of partner abuse to women’s risk of mental disorders. To conduct a meta-analysis, she combined all the data from all the studies she collected and analysed them as one group to find the rate of each disorder among abused compared with non-abused women. Golding limited her analysis to studies of physical abuse and did not include violence between same-sex couples or pregnant women, as these had additional stressors. She examined the impact of partner abuse on disorders including depression, suicidality, post-traumatic stress disorder and drug and alcohol misuse separately and the findings are outlined separately below. Golding found strong evidence for the contribution that partner abuse makes to women’s mental ill-health.

**Depression**

Depression is predicted to become the second most important cause of disease burden* in the world by the year 2020 (Astbury & Cabral 2000). Golding found that just under half (47.6%) of all abused women suffered from clinical depression compared with 10 to 20 per cent in women in the overall community. Abused women were three times as likely as non-abused women overall to be diagnosed as depressed. Three studies demonstrated that the longer women were away from the abuse, the greater the decline in their depression, demonstrating a close association. Five studies indicated that the more severe the abuse, the more severe the depression, illustrating the dependent relationship between the length of time a woman experiences abuse, its severity, and the subsequent degree of impact on her mental health.

**Suicidality**

Thirteen studies of suicidality demonstrated that abused women were three and a half times more likely to be suicidal than non-abused women, but this varied considerably across the populations of women, for example, depending on whether they were women in refuge (who were more prone) or hospital patients.

I was always scared of dying but it’s nice and peaceful when you’re dead. Because that’s all I wanted, I wanted peace and it was nice where I was and then I woke up and I thought, ‘Oh, no I’m back here again’. Because I hated life. (Head & Taft 1995)

**Post-Traumatic Stress Disorder (PTSD)**

PTSD is a recognised psychiatric disorder first associated with men returning from the trauma of war. Its symptoms include increased psychological arousal, intrusive thinking (re-experience of the trauma), trouble sleeping and concentrating, irritability, being watchful and jumpy, physiological arousal, fear, avoidance, hyper-vigilance and psychic numbing, including dissociation*. The stressor criterion for the diagnostic category of PTSD states that a ‘person must have experienced, witnessed, or been confronted with an event or events that constituted a threat to the physical integrity of self and that this event must have provoked a response evoking fear, helplessness and horror’ (Mertin & Mohr 2000, p. 412). Walker first defined the constellation of symptoms found in abused women as the Battered Women’s Syndrome. She later however, regarded it as a sub-classification of Post-Traumatic Stress Disorder or PTSD.

Post-traumatic stress offers a broader conceptual framework than depression from which to view the constellation of outcomes of violence against women. This framework can include depression and anxiety as co-morbid disorders but post-traumatic stress is not reducible to these disorders. (Astbury & Cabral 2000, p.80)

Golding found the combined studies showed the majority (63.8%) of victimised women suffered traumatic stress symptoms compared with only 1.3 to 12.3 per cent of women who had not been victimised. Abused women were found to be almost four times more likely than non-abused women to be experiencing PTSD. Five studies showed that the
more severe or the longer the abuse was sustained, the more severe or prevalent was PTSD. In one study, the strongest predictors of the extent of PTSD were: the use of disengagement* strategies to cope with the battering; the experience of other negative life events; the experience of assault itself; and the lack of perceived social support (Kemp et al. 1995 cited in Mertin & Mohr 2000, p. 413).

I’ve put a phone in and I take my mobile to bed every night. I keep [internal] doors wide open so I can hear through all the house and I sometimes don’t sleep anyway…I have panic attacks…all my [external] doors have bolts and clip-ons and locks and bolts and more bolts and all my windows are nailed shut (Mary) (Humphreys & Thiara 2003, p.214)

A different and comprehensive review of 43 studies by Jones et al. (2001) of PTSD and domestic violence found that 31 to 84 per cent of victimised women exhibit PTSD symptoms, depending on the sample. The highest prevalence was among women in refuges/shelters. They found that multiple victimisation (e.g. childhood and adult sexual abuse) increased the likelihood of PTSD and other disorders and concluded that the extent, type and severity of the abuse affected the levels of PTSD. They suggested that younger, unemployed women with a relatively large number of children, low income and low levels of social support are more at risk of developing PTSD and other mental health problems than other women (Jones et al. 2001).

I remember the exact words, which is what my husband was saying when he was kicking me and that was, ‘you don’t understand, you only live because I let you live. You only breathe because I let you breathe.’ (Head & Taft 1995)

Drug and alcohol misuse

Golding found that victimised women were almost six times more likely than non-abused women to misuse alcohol. Eighteen and a half per cent of women who had experienced partner violence misused alcohol in comparison with between 4.6 to 8.2 per cent in the general community. Almost nine per cent of abused women misused licit or illicit drugs and they were five and a half times more likely to do so than other women. In the quote below, a woman describes how easy it was for her to get sleeping pills from her doctor, who felt unable to ask about what was really happening to her that caused her insomnia.

I knew that he would prescribe anything, I knew that, because I asked him for Mogadon, which is one of the strongest sleeping tablets. He’d prescribe them to me and there were 25 in the packet and then like a week, a week and a half later, I’d go back and ask for more. (Head & Taft 1995)

Despite the limitations and variability of findings, Golding concluded from the meta-analysis that the prevalence of mental disorders among women who have experienced partner violence is high. She also argued that PTSD is considered by specialists to be the most appropriate diagnostic category even though depression may be present, because it may mask PTSD and be symptomatic of it. Golding’s meta-analysis revealed different impacts on women’s mental health depending on the frequency and severity of partner abuse. She commented that ethnic or cultural differences among women and their mental ill health had not been systematically evaluated. Recent studies are revealing different forms of partner abuse that have different impacts on women’s mental health and may therefore require different responses (Johnson 1995; Hegarty & Roberts 1998; Hegarty 2002). This is explored in the following section of the paper.

Forms of violence and mental health

Johnson (1995) first described differing patterns of violence and control among different communities of couples, the first of which he defined as ‘common couple violence’ (those women and men using equally violent acts which Straus and Gelles found in their studies with the CTS). He then described ‘intimate or patriarchal terrorism’ which equates with accepted definitions of domestic or intimate partner violence which emphasise the coercive and controlling tactics used by abusers. Johnson & Ferraro (2000) later argue that it is important to distinguish between the contexts of relationships, such as the additional pressure faced by victims in gay and lesbian relationships, the different pressures faced by those in dating couples and those who cohabit. They point out that the impact of the violence may depend on where the woman herself and those around her attribute blame. The authors explore the social consequences of violence and the impact of violence on a woman’s capacity to work, her independence and her sense of self-worth. They argue that a better theoretical and practical understanding of the nature of partner violence is vital to providing a more sophisticated context for developing effective responses.

Further evidence for the importance of some kind of distinction in types of abuse is a new study (Coker et al. 2002), which demonstrates the different impacts on the mental health of abused women depending on the type of violence they are experiencing. Coker et al. distinguished differences in levels and types of abuse: forced sexual abuse (severe abuse, including physical and emotional abuse); physical abuse (no sexual, possible psychological abuse); and psychological abuse alone. Their study involved 1152 women aged between 18 and 65 from two US family practice clinics.
Significantly more women reporting sexual (severe) abuse had partners with substance abuse problems and were older, unemployed and separated. There is a distinct pattern of effects with women with severe abuse reporting almost three times as much mental health disorder, women with physical abuse almost twice as much, and psychologically abused women 1.7 times as much, as those who are not abused. The same gradients (from high among severe, middling levels among the physically abused to lowest among emotionally abused women) occur for physical health outcomes, substance use, specific anxiety and depression disorders including PTSD and suicide attempts. For the majority disclosing abuse, disclosure itself was not associated with a significant reduction in risk of any adverse mental health outcomes, unless the listener’s response to the disclosure was repeatedly supportive. Abused women with higher levels of social support were less likely to report current poor mental and physical health than abused women with lower social support, irrespective of the severity or frequency of the abuse. The authors conclude that: there are demography differences (such as age, employment and marital status) between women experiencing these different types of abuse; disclosure itself is not sufficient to reduce mental health damage; but that the presence of social support makes a significant difference, especially to suicide attempts (Coker et al. 2002).

**Co-morbidity**

As many studies indicate, the greater frequency of depression and anxiety among abused women highlights the co-morbidity* (or co-existence with another disorder) of such distress among women, although the rates between countries vary widely. The existence of co-morbidities, such as mental health disorders including PTSD and substance abuse, has implications for health promotion and recovery services. The WHO study found that co-morbidity rates exceeded 50 per cent and that this was most prevalent among depressed patients (Astbury & Cabral 2000).

**Australian studies**

In 1988, a landmark Queensland study conducted a phone-in survey of over 600 domestic violence victims. Of these victims (the majority of whom, 93%, were women), 293 (44%) reported psychological problems, 105 (16%) experienced a ‘nervous breakdown’ and 41 (6.2%) reported stress-related illness (Queensland Domestic Violence Taskforce 1988).

In 1998, Gwen Roberts and her colleagues wanted to explore the types of psychiatric disorders abused women suffered and what, if any, were the risk factors (Roberts et al. 1998). They studied 335 Brisbane women who presented to the Emergency Department and found that 48.4 per cent reported a lifetime history of partner abuse. Those who did report abuse had significantly more psychiatric diagnoses than those who did not, while women who experienced both child and adult victimisation had the highest rates of all psychiatric diagnoses (phobias*, depression, dysthymia*, anxiety, somatisation*, harmful alcohol consumption and drug dependence). Lifetime prevalence for PTSD was 48.5 per cent for women who had experienced both forms of abuse, 37.5 per cent for women abused only as a child, 30.6 per cent of those abused only as adults, and 13.7 per cent of those not abused. They concluded that women who had experienced both types of abuse had the greatest risk for later mental disorders. A further important conclusion from the study was that women who lived as children with abuse between their parents had an independent risk for phobias, dysthymia and anxiety, whether abused as adults or not (Roberts et al. 1998). These findings are consistent with Jones et al.’s meta-analysis.

A recent study of 100 women leaving Adelaide shelters found that forty-five of the residents met all the diagnostic criteria for PTSD (Mertin & Mohr 2000). The findings are consistent with those from overseas. Half had experienced violence in their childhood. The 45 per cent of women meeting the PTSD criteria reported higher levels of violence and were more likely to report having a partner with an alcohol problem whom they believed could ultimately kill them, than those without PTSD symptoms. The most frequent symptoms they experienced were recurrent intrusive thoughts and feelings about abuse, conscious efforts to avoid thinking about it, sleeping difficulties, difficulties with concentrating and hyper-vigilance. They also experienced more significant depression than women not abused (Mertin & Mohr 2000).

For the majority disclosing abuse, disclosure itself was not associated with a significant reduction in risk of any adverse mental health outcomes, unless the listener’s response to the disclosure was repeatedly supportive. It is clear from these studies that abused women suffer much more mental distress and disorder, particularly depression and PTSD, than women not abused. Often these disorders co-exist in women and are more pronounced if women were also abused as children. It is also evident that the more frequent and severe the abuse, the greater the scale of disorder. The highest rates of mental ill-health have been found among women in refuges. However,
the evidence suggests that symptoms often reduce or may disappear, the further in time women are removed from the abuse.

Often when women leave refuge, they enter a life of poverty and sometimes, later homelessness. These further stresses can also impact on a woman’s mental wellbeing. The next section discusses why a social ecology* of health is essential to understanding women’s mental health and illustrates, with recent research on cycles of deprivation, how intimate violence interacts with homelessness and recreates female poverty through its impact on mental health.

For women, refuges often represent an escape from abuse but into the trap of homelessness and poverty, from which it is difficult to escape. They may then also be vulnerable to more violence or abuse.

The social model of health – intimate violence, homelessness, poverty, social conflict, immigration and women’s mental health

...a woman experiencing violence in her own home is in a very real sense, homeless. (Astbury & Cabral 2000, pp. 65-66)

Growing up female plays a powerful role in shaping women’s vulnerability to mental disorders. In some countries there are many factors which exacerbate this vulnerability, such as the general level of violence in the society, women’s access to economic resources and their legal and cultural position. The relationship between socio-economic status, social class and health status is one of the most consistent findings in epidemiological research (Kennedy et al. 1998). However, the relationship between low socio-economic status and high rates of psychiatric disorders has been argued to have two different explanations. The first explanation is that those with psychiatric illnesses or characteristics predisposing them to such illness are pressured downwards into these groups and fail to rise out of them. The second is that the greater environmental and psychological adversity which exists in low socio-economic populations, produces high levels of stress and depression. This is in tune with Brown and Harris’ (1978) findings about women and depression.

For women, refuges often represent an escape from abuse but into the trap of homelessness and poverty, from which it is difficult to escape. They may then also be vulnerable to more violence or abuse. A recent Australian report into the links between domestic and family violence and homelessness, criticised the prevailing model of intervention which forces women and children to leave their homes and neighbourhood in order to respond to a male partner’s violence (Chung et al. 2000). Women in refuges or shelters experience high rates of mental distress and few social support networks. Together with pre-existing poverty, unemployment, the low affordability of housing, especially on the private rental market, women’s declining social and economic paths all contributed to generating homelessness. Women who are insecurely housed, as women in refuges are, are prone to increased stress as a result of their concern over their own and their children’s safety, lack of social support and longer-term security. In this context, the professional tendency to diagnose ‘personality disorder’* among abused homeless women has been criticised:

Personality disorder is a diagnosis of social dysfunction and does not take into account the influence of environmental factors extrinsic to the organisation of the personality such as poverty, racism and gender bias. (Bassuk, Rubin & Lauriat 1986 cited in Astbury & Cabral 2000, p.59)

As if to confirm how partner abuse exacerbates poverty and these combined can impact on women’s mental wellbeing, Tolman and Rosen (2001) conducted a study of a random sample of 753 women receiving welfare in an urban, U.S. city. Over half the sample were African-American, most were young with small children and only 24 per cent were living with their partner. Just over half (51%) had experienced severe lifetime abuse, 14.9 per cent in the past year. Just under half of the women currently experiencing severe violence had experienced direct work interference by their partners. They suffered two to three times the rates of depression, anxiety disorder and lifetime PTSD than national female norms. Current victims had higher rates than past, reinforcing the association over time. Recent domestic violence was associated with having any mental disorder and with substance misuse. Recent victims were more likely to have been homeless, have faced eviction, had their utilities shut off and to have experienced food insufficiencies. Both past and present victims experienced increased risk of material hardship when other factors were controlled (Tolman & Rosen 2001).

Recent interpretations of the observed gender differences in psychiatric morbidity suggest that in developing countries in particular, poverty, domestic isolation, powerlessness (from low levels of education and economic independence) and patriarchal oppression (e.g. dowry burnings) are all associated...
with the higher prevalence of mental disorder and point to the social origins of psychological distress for women (Desjarlais et al. 1995, p.183). For example, women may be less valued and less nourished in times of scarcity. Sixty per cent of women in developing countries are undernourished and clinically anaemic, which contributes to women’s feelings of anxiety and depression. Many studies of women’s work in comparison to men’s find that women work longer hours, particularly in developing countries, and that this increased burden contributes to levels of what may often be described by women as ‘nerves’ (Desjarlais et al. 1995, p.188).

However, another major contribution to women’s mental disorder is the actual or threatened violence over their lifespan. Intersecting and interacting with poverty - rape, female sexual slavery, trafficking and prostitution and the threat of STDs and HIV/AIDS and other forms of violence against women – may be separate from, or in addition to, partner abuse/domestic violence. The methods of violence and cultures of fear used by some nation states exacerbate the external environment of fear, demoralisation and trauma further experienced by women in their home (e.g. detentions, torture and disappearances in oppressive military regimes). Desjarlais et al. (1995) report that many women fled El Salvador from domestic violence as much as from state violence, stressing however, that it was unclear whether the state violence had increased the frequency and severity of the domestic violence.

These findings have relevance for the mental health of women in the ‘developed’ countries to which refugee and immigrant women come. While some immigrant and refugee women have strong coping strategies, others who may have experienced forms of abuse in their home countries, and some abuse in Australia, may not. Managing the additional stresses of immigration however, is different among victimised women from diverse cultures. In a small random community study of the effects of immigration status on abused women’s coping strategies, Yoshihima (2002) found that the relationship between a woman’s country of birth, the choice and perceived effectiveness of her coping strategies, and her psychological distress, was complex. For Japan-born Japanese-American women, the more effective they perceived ‘active’ strategies (observable, behavioural efforts), the higher their psychological distress, whereas the more effective they perceived their ‘passive’ strategies (unobservable, cognitive or emotional efforts), the lower it became. In contrast, the US born Japanese-American women experienced less distress with effective ‘active’ strategies, while passive strategies had little effect. Women’s coping strategies can therefore vary widely and health professionals need to carefully elicit a full history to effectively manage their support.

Sometimes however, the context can be overwhelming. One recent extreme Australian example was the suicide in a NSW detention centre of a young Thai woman trafficked into sexual slavery in Australia at the age of 12. When discovered in a brothel without legal immigration papers, she was put into detention prior to repatriation. The drugs she abused to cope with her desperate situation gave her the means to overdose or suicide (Maltzahn 2002).

This discussion confirms the value of eliciting and understanding the ecological context in which women are abused. Intimate abuse can be compounded by poverty, racism or previous war trauma. If this is not acknowledged and ameliorated, its invisibility or oversight can compound the damage to women’s mental health caused by the abuse. Otherwise broader societal and institutional abuses, explicit or implicit, can compound the intimate damage. Immigrant and refugee women in particular may have experienced multiple forms of violence over their lifespan that can exacerbate their suffering. In addition, as culture is dynamic, women may have different cultural responses to forms of intervention and may differ in their coping mechanisms depending on their degree of cultural adaptation.

What are the mechanisms through which such damage occurs? The following section explores how traumatic damage can be inflicted and why it is similar to the trauma experienced in situations of armed conflict and captivity.

**Understanding the relationship between intimate violence and mental health – the role of coercion and entrapment and complexity**

*He kept me here hostage for five days. I asked for a doctor three times over the weekend and he refused (after a severe beating).* (Head & Taft 1995)

*I couldn’t even walk outside without getting my head kicked in, I wasn’t allowed outside the house. I had to stay inside all the time. I was only allowed outside with him you know, and I had to walk with my head down, I wasn’t allowed to look around.* (Head & Taft 1995)

The discussions to date have provided evidence for the complex inter-relationships between gender and social inequalities, their impact on women’s experience of partner abuse and women’s subsequent mental illness burden. This section will analyse within a social health framework, the current theories about how the critical factors of entrapment,
coercion, control and humiliation in intimate violence impact on women's mental health.

When the victim is free to escape, she will not be abused a second time; repeated trauma occurs only when the victim is a prisoner, unable to flee and under the control of the perpetrator...a man's home is his castle; rarely is it understood that the same home may be a prison for women and children...women are rendered captive by economic, social, psychological and legal subordination, as well as by physical force...it is not necessary to use violence often to keep a victim in a constant state of fear...battered women frequently report that their abuser has threatened to kill their children, their parents or any friends who harbour them, should they attempt to escape. (Herman 1992, pp.74, 77)

Judith Herman’s classic text Trauma and Recovery (1992) describes the troubled history of the diagnostic label of 'hysteria'. She vividly outlines in what Johnson (1995) would describe as ‘intimate terrorism’, the perpetrator’s need not only to dominate and completely control, but also his need for affirmation of his justification to do so, from his victim. Her book evocatively describes the conditions of fear, disconnection and captivity common to combat veterans and chronically abused women. Her theories have evolved from other studies exploring the links between social status and depression, such as the earlier work on the social origins of depression undertaken by George Brown and his colleagues.

Women’s perceptions of their place in the scale of things, including the consciousness of lower social position, has been suggested as one of the underlying mechanisms influencing the rates of mental disorder in general, and depression in particular, among women. Following their earlier pioneering work, Brown et al. developed a new measure for understanding the severe events which lead to depression. Humiliation and entrapment emerged as highly significant predictors of the onset of depression when severe events occurred. In their study, almost two thirds of events in the six months prior to the onset of depression involved being trapped and humiliated and three quarters of severe events involved such circumstances (Astbury & Cabral 2000). Women are thought to have a strong ethic of care and invest greatly in personal relationships. Devaluation and rejection in relationships can increase the likelihood of distress and depression. Jack argued that women's inability to change the poverty of some intimate relationships and their consequent self-censorship, led to a muting of the authentic self and a concealment of anger, which she called ‘the roar which lies on the other side of silence’ (Jack 1991, cited in Astbury 1996, p.29).

Other perspectives support the idea that depression in particular is closely linked to a sense of loss and defeat. This is especially the case among situations characterised by entrapment and humiliation, which suggest devaluation and marginalisation. The descriptions of victims’ features in social rank theory, which inhabit these other theoretical pathways to depression, are familiar among victims of severe partner abuse. Victims hold:

Perceptions of the self as inferior or in an unwanted subordinate position, low self-confidence and behaving in a submissive or non-assertive ways, having a sense of defeat in relation to important battles and at the same time, wanting to escape but being trapped. (Astbury & Cabral 2000, p.40)

These characteristics and their relationship to depression could be observed in countries as varied as England and Zimbabwe. Thus social rank, together with gender and theories about the influence on humiliation and entrapment, pose a powerful theoretical explanation for women’s vulnerability to mental disorders and their burden of co-morbidity.

Violence, by forcing submission and reinforcing inferior social ranking and subordination, engenders a sense of defeat and a loss of self-esteem. (Astbury & Cabral 2000, p.77)

Well I remember thinking 'I'm going to have to kill myself' because I can't. I didn't think I would ever stay away from him... So well me life was at risk really. I had no life. I had nothing. I had me kids... then I thought me kids would be better off without me because... it were like I had no control over anything, to what I wore, to when I went to sleep, to when I woke up; everything I did was what he let me do really (Gail). (Humphreys & Thiara 2003, p. 215)

Like Gail (above), women in this UK study spoke of the many ways men tried to control them, and the humiliation of sexual and bodily control, which could lead them to attempt suicide or develop other mental health problems (Humphreys & Thiara 2003). In contrast to humiliation and entrapment, autonomy and control can mediate against the risk of depression in the context of loss, for example, of a relationship which was thought to offer support. Brown et al. (1995) found that when women initiated separation, only about 10 per cent suffered depression, whereas when another initiated the separation, about half the women developed depression (Astbury & Cabral 2000). When women leave their violent partners and are able to distance themselves from violence, humiliation and entrapment, their depression, anxiety and other symptoms of mental disorder decrease. The next section discusses the terminology of psychiatric and psychological illnesses and the impact such diagnoses and the meanings ascribed to them can have on women. It also discusses the responses from health institutions aiming to support women's recovery and their strengths and limitations.
Diagnosis and dual victimisation – the limitations of current institutional responses

Diagnosis

Diagnosis is a conceptual method with which mental health practitioners attempt to understand and frame a patient's experience in a recognised typology in order to prescribe treatment and improve the prognosis or future health outcome. However, in many societies, having a diagnostic label may be unhelpful or damaging, as it can also lead to stigma, shame, discrimination and isolation. In many cases of domestic violence, the violence is not diagnosed. Diagnosis may be the means by which health providers interpret and label the symptoms with which women present and the professional pathway to prescribed treatment. This section seeks to explore the differing arguments about how women's mental illness should be diagnosed or interpreted and the implications for the women themselves, for policy and for intervention.

The victim-blaming explanations of ‘sin’, ‘evil’ and ‘possession’ which first characterised early religious interpretations of women’s ‘madness’ led to burning women as ‘witches’ or exorcism. The later ‘scientific’ diagnosis of hysteria, brought some tolerance and compassion for victims, but not a better understanding or treatment of the underlying issues. Hysteria, neurosis and other forms of psychopathology such as masochism, were diagnoses with which women were labelled and treated ineffectively for many years. The links made by Freud and Helene Deutsch between women’s reproductive system and their mental health led to various theories about how women’s reproductive system and nervous dispositions led to postnatal depression and other mental disorders after childbirth, with no consideration of alienating birthing processes, restricted roles for women or any knowledge of violence in pregnancy (Astbury 1996).

Some of the theories used to explain the mental health consequences of partner abuse which have been outlined in this paper, have led to the many diagnostic labels now thoroughly criticised by contemporary scholars. As Fishbach and Herbert (1997) note, following the advent of the refuge and shelter movement in 1971 and the emergence of an activist-based empowerment paradigm for understanding (partner) violence, feminist psychiatrists began a re-evaluation of women who were being battered. From the late 1970s, Walker’s ‘learned helplessness’ evolved into the ‘battered women’s syndrome’ and Walker wrote critically of the need for mental health service providers to learn about the impact of cycles of abuse on women’s mental health and to respond appropriately (Walker 1984).

Lynn Rosewater (1988) explored how currently and previously battered women responded on a common diagnostic tool for psychiatric illness, the Minnesota Multiphasic Personality Inventory (the MMPI). She wrote critically about how battered women were previously badly misdiagnosed using the MMPI, with what was termed ‘masochistic personality disorder’ and later ‘self-defeating personality disorder’. This misdiagnosis had serious clinical implications for how women were then treated, with the battering invisible and the symptoms treated as innate pathology. Rosewater showed that violence intensifies psychological disorders and symptoms and that abused women appear similar to schizophrenic women on this major diagnostic scale. She also noted that women were frequently misdiagnosed with borderline personality disorder* (BPD). Rosewater argued that these traits are not character traits, but reactive. She argued further that the mental health system, in using such diagnostic tools, can misinterpret what appears to be paranoia, for example, in women who have every reason to feel fearful (Rosewater 1988).

Diagnosis is a cornerstone of the mental health system. However, mental health service providers often do not understand the implications of partner abuse or the implications of misdiagnosis for women with symptoms of mental disorders associated with domestic violence. In a recent debate, Candib (1995) took issue with Sansone et al. (1995), who advocated the use of the diagnosis of Borderline Personality Disorder (BPD) in women with symptoms resulting from childhood or adult violence or trauma. She objected to the diagnosis of BPD, as she argued that the term implied an indwelling pathological permanence from which one could not recover. These and other stigmatising labels, which offer no clear link between abuse, trauma and a woman’s response, let alone the ecological context in which she makes sense of the risk to herself and those for whom she cares, may result in highly inappropriate treatment. It can also lead to other wider detrimental effects, such as losing health insurance or the custody of her children, because she is ‘mad’ and/or ‘bad’. Many women fear that their partners or partners’ lawyers will use such diagnoses and labels to remove the children from their custody in the...
Whenever a woman discloses, what is critical is the quality of the response she receives, the attribution of responsibility for the violence that she and her confidante make, and the levels of social support she receives.

The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the patient’s present symptoms and the traumatic experience is frequently lost. Attempts to fit the patient into the mold of existing diagnostic constructs generally result, at best, in a partial understanding of the problem and a fragmented approach to treatment. (Herman 1992, p.118-119)

Herman called for a new concept. She suggested that the syndrome which followed ‘prolonged, repeated trauma’, should be called ‘complex post-traumatic stress disorder’. Battered women suffer from a complex constellation of symptoms which is similar to PTSD, but which includes additional symptoms including depression, anxiety, idealisation of the perpetrator and dissociation*, due to the chronic nature of the trauma. This category may be limited to severely abused women and also to traumatised survivors of torture, war, religious cults etc. Early childhood abuse exacerbates the trauma women experience from partner abuse and if they also witnessed partner abuse in childhood, this could independently cause symptoms of mental disorder. Many others support the idea of this diagnosis (Harvey 1996; Astbury & Cabral 2000; Jones et al. 2001).

For women with severe mental disorders, diagnoses may be unavoidable, but do all women require diagnoses as a prerequisite to recovery? Herman outlined the important role which community, social support and wider cultural and environmental influences can play in helping or hindering victims to respond, independently of any clinical help. This theme is taken up more strongly by Mary Harvey (1996). She argues that, while clinicians may see the variations in individual victims’ symptoms as solely or primarily related to their pre-traumatic attributes, in fact the extent and duration of traumatic exposure, the characteristics of traumatising events, the ways individuals interpret the events and qualities of the larger environments, are equally important. For women’s mental health promotion, Harvey highlighted the need to consider how community values, beliefs and traditions can strengthen community members and support their resilience in the face of violence or contribute to further harming them.

Whenever a woman discloses, what is critical is the quality of the response she receives, the attribution of responsibility for the violence that she and her confidante make, and the levels of social support she receives. If the responses are unsupportive, or inadequate, they can compound the problem.

I told him... 'this time I need help'... I was very down. I need something to stop me, to keep me up, because

Dual victimisation – the limitations of current institutional responses

Stark and Flitcraft (1996) argue that partner violence is a necessary but not sufficient explanation about what elicits traumatic response to battering. In common with Gondolf et al. (1998) and others, they argue that this results from a conjunction of structural discrimination, barriers to institutional access, inappropriate responses and the perpetrator’s coercive control. Hence the paper now turns to an examination of where problems lie in some current approaches. The need for reform in primary health, mental health care and substance misuse services, is also discussed.

Abused women seek help from health services more often than women who are not abused. The more severe violence a woman experiences, the more often she seeks help from health care services (Koss et al. 1991). Clinicians who do not understand the links between abuse and mental illness may focus on the intrapsychic symptoms and misinterpret these as chronic psychopathology (Jones et al. 2001, p.113). Many studies have described these patterns of response in Emergency Departments, mental health and primary health care services (Stark et al. 1979; Head & Taft 1995; Stark & Flitcraft 1996; Kim & Motsei 2002). They may result in inappropriate medication, especially benzodiazepines*, which women say can place them at greater risk. For example, they may be so affected by the medication that they are oblivious to heightened risk of violence
from their partner. It may also result in women avoiding or rejecting health services following an initial unsupportive response; hospitalisation as either a voluntary or involuntary patient (where she may be at risk of further assault); or damaging treatment, such as couple counselling, which ignores the violent context and places the woman at greater risk (Bograd & Mederos 1999).

Because of what I was going through I wanted to be in touch with the way I felt. I didn't want to take drugs to alter the way I felt. I didn't want to feel better about something that wasn't better. (Head & Taft 1995)

Women may want help from health services for the mental trauma they are experiencing, but still be unable to disclose it. Professionals will rarely ask directly about abuse, even if they suspect that this may be the underlying problem (Hegarty & Taft 2001). Two recent UK studies of victimised women's experiences of mental health services, found that women they interviewed clearly identified the links between their distress and experiences of domestic violence and sexual abuse (Humphreys & Thiara 2003; Prendergast 2002). Many found it difficult to find help when they were least able to (feeling at their lowest). They recognised the important role of General Practitioners in enabling them to access services but realised that GPs' lack of awareness, time and knowledge of services prevented them offering appropriate help. Mental health workers' and other community workers' responses ranged between helpful and unhelpful, but most women found psychiatrists and in-patient psychiatric services to be unhelpful. In the UK studies, psychiatrists were perceived as lacking interest in the causes of their distress, to have minimal contact time, and as showing disrespect. Victimised women considered that their psychiatrists did not offer trauma counselling which took account of the controlling tactics and violence of the perpetrator. Such oversight contributes to maintaining the invisibility of the abuser. Many women in the Leeds study (Prendergast 2002) spoke about extreme difficulties they faced in crisis and reported that they found the hospital unhelpful and were afraid for their safety, particularly in mixed wards.

The hospital was absolutely disgusting. I went in during the split. I took an overdose, because he was constantly on the phone...they treated me terribly...I did hear a couple [medical staff] in the corridor saying 'There's an OD case, domestic violence. She's been in before, just leave her. She'll be out by morning.' (Kim) (Humphreys & Thiara 2003, p. 217)

In common with an Australian study of GPs (Head & Taft 1995), Graham's (1995) study of 31 sexually abused women and mental health services revealed expectations of a disclosure that:

- the person disclosed to would intervene and prevent further assault
- the girl or woman would be given 'permission' and encouraged to share her feelings about the assault/s
- mental health professionals would provide or arrange follow-up counselling to assist the woman to talk about her feelings about sexual assault and resolve related issues.

The damaging entrapment and humiliation in the power imbalance between a victim and abuser may be amplified if it is replicated in a health provider's response to a woman's victimisation (Graham 1995; Head & Taft 1995). Most responses in the Leeds study were perceived as denials or trivialisations and women consequently reported feelings of invalidation and re-abuse. Jones argues that poor responses may not only be ineffective, but may also be experienced by survivors as blaming of them. This reinforces their low self esteem and lack of control over their own mental status (Jones et al. 2001, p.113).

...I started becoming anorexic...that's when I ended up trying to commit suicide. I went on to a psychiatric ward. I didn't get much help from that. It was basically about eating, nothing to do with...why I was like I was. (Humphreys & Thiara 2003, pp. 216-217)

When health providers listened, responded and empowered women to regain control and move on in positive ways, their power to reshape the women's lives was met with overwhelming gratitude (Prendergast 2002). Any affirmation could be transformatory:

I disclosed the sexual assault to the psychiatrist...the questions she asked me started to make sense of 40 years of confusion...when I finished with the psychiatrist I had this feeling of power that for the first time in my life I had power over my life. (Graham 1995)

Once a month we'd [woman and her sons] front up to the court house and we'd go to Dr M. beforehand and say – we're off again. And he'd say, remember the meditation, remember this, remember that, this might help you. And he was great, really wonderful. There should be about 15 million more like him. (Head & Taft 1995)

Campbell (2002) points to the evidence that the majority of the greatly increased costs incurred by victimised women seeking help derive from the ‘revolving door’ of inefficient mental health services. However, mainstream health services cannot respond effectively alone, given the co-morbidity which many women experience, the diversity of the forms and severity of the abuse and the
complexity of women’s contexts. This complexity may include cultural and linguistic diversity and immigrant or refugee status. A more effective response will involve collaboration with specialist services, which should include domestic violence or sexual assault, drug and alcohol and/or interpreter services. Good collaboration will require better mutual understanding between mental health and specialist violence services. However, this collaboration must address significant differences in perspective between the two systems. Developing effective and collaborative responses by primary and mental health care services together with specialist domestic violence services should ensure better pathways to address what is a challenging problem for services and a profound and neglected problem for women. The next section considers how this can be achieved at all levels of society’s responses.

Gendering mental health promotion for women

The concluding section discusses the changes and connections needed in society, at community and health system level and at the level of the individual service provider and woman interaction, which maximise the potential for a gendered mental health promotion strategy and for rebuilding victimised women’s mental wellbeing. The model recognises the need for a holistic approach that maximises benefit at all levels of an ecological model. It draws from Heise, Harvey, Herman and Gondolf and pulls together the implications of the evidence above for future mental health promotion and effective responses to the needs of women experiencing intimate violence. First, discussion focuses on the level of society, which is where the major population impact is felt and where national and state policies can bring beneficial health gain to women.

Society

Violence against women is endemic, especially partner abuse. It is a significant cause of mental and physical ill health in every culture in the world. Maslow’s classic hierarchy of human needs put safety next after the primary need for basic survival. Recently human rights organisations have begun to argue that intimate partner abuse violates women’s rights. Fishbach and Herbert cite Beasley and Thomas (1994) to argue that:

...failure to prosecute perpetrators of domestic violence against women reflects a pattern of gender-based, systematic, discriminatory non-enforcement of national criminal law which differentially disadvantages women and puts their mental health and, indeed, their lives at risk simply because of their gender. (Fishbach & Herbert 1997, p. 1162)

The social origins of women’s mental health leading from the global analysis outlined above point to the overwhelming importance of support for the empowerment and protection of women in wider society. Recognition of women’s multiple roles, and a gender analysis of programs, is required to identify any policy or program developments, which will impact detrimentally on women (World Health Organisation (WHO) 2002).

Healthy policies for women are supported by state gender ideologies that enhance the cultural, political and legal status of women by legitimating equitable public investment in and protection of females as well as males. (Desjarlais et al. 1995, p.203)

Whilst this is especially relevant to developing countries, in Australia, laws relating to all forms of discrimination, but particularly sexual discrimination, equal opportunity and harmonisation of progressive domestic violence legislation across states, are also essential. A significant society-wide initiative is the development of a strong climate of zero tolerance of intimate violence against women. Health professionals are known to share the attitudes to violence which prevail in the general community. Changing community attitudes to those with less tolerance of gender violence and encouraging an understanding of barriers impeding women’s ability to change or leave, will impact on health professional attitudes as well (ANOP Research Services 1995).

Equally important is the development of data analysis, training, and the development, monitoring and evaluation of policies and programs relating to violence against women (especially partner abuse) in the public health system. This should include mental health, primary health care, substance misuse services, reproductive health (birthing, termination and sexual health services) and others. Such critical change processes would enhance the quality and effectiveness of care and reduce the associated costs of the ‘revolving door’ syndrome of repeat episodes of care. In narrow health behaviour terms, women who are abused smoke, binge drink and eat less well than women who haven’t experienced abuse (McNutt et al. 2002). Reducing the abuse and trauma in women will have many other benefits in reduced harms (World Health Organisation (WHO) 2002).

Community and the Institution

Several recent reviews and books have clearly outlined critical features of an effective, good practice response to women’s disclosure of abuse (Herman 1992; Harvey 1996; Warshaw 1996, 1997; Gondolf 1998; Heise et al. 1999; Warshaw & Alpert 1999; Garcia-Moreno 2002). Warshaw, Gondolf and Garcia-Moreno (WHO rapporteur for violence against women) outline the need for health services to transform practice at the systemic, institutional
and provider level. They highlight that some health services have abusive or restrictive practices, which work against good practice. For example, hospitals in which the hierarchies of professionals are damaging to subordinates may encourage subordinates to act in a similarly unsupportive manner to patients. Intake assessments, which have closed questions, do not allow a woman to account for the wider pressures impacting on her mental health.

Gondolf outlined the differing perspectives between battered women’s programs and formal mental health services, which can lead to problems, which need to be overcome before the two systems can embark on a more collaborative pathway. These different perspectives, somewhat starkly dichotomised, on theoretical constructs, aims and objectives are set out in the table below (Gondolf 1998, p.7).

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<th>Dimension</th>
<th>Battered Women’s Programs</th>
<th>Mental Health Services</th>
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<tr>
<td>Type of analysis</td>
<td>Sociological</td>
<td>Psychopathological</td>
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<td>Problem view</td>
<td>Social problem</td>
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<td>Services provided</td>
<td>Safety, resources, sanctions</td>
<td>Medication, psychotherapy and hospitalisation</td>
</tr>
<tr>
<td>Social aim</td>
<td>Institutional change and social reform</td>
<td>Individual coping with stressors and adjustment to society</td>
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Whilst reform is needed in all health services, it is only very recently that attention has turned to the changes required in mental health and substance misuse services. There is an ongoing major debate within the health system about the value of screening for partner abuse in health services, before the health system is appropriately prepared to manage the problem effectively and sustainably. This debate centres on whether disclosure is a beneficial action in itself, whether health care services are adequately prepared to respond beneficially and effectively to abused women’s particular needs, and whether there is sufficient evidence for which interventions are most effective (Campbell 2000; Davidson et al. 2000; Taft 2001; Campbell 2002; Ramsey et al. 2002). This paper has produced some evidence for the fact that disclosure may not be beneficial in itself, unless the response is repeatedly supportive, and that mental health services are often developed with models that are ill-equipped to respond to the needs of abused women. This does not mean that health professionals should not inquire directly or act on suspicion of intimate abuse. However, it can be argued that more needs to be done to improve the health system itself, including enhancing the capacity of health providers to respond, before widespread screening is introduced in primary health care or mental health specific services.

Gondolf’s 1998 book, *Assessing Woman Battering in Mental Health Services*, outlines pathways to recognising the organisational barriers to good practice. Mental health services require an evaluation process to identify the barriers (any inappropriate treatment or professional status barriers) to closer collaboration with domestic violence services. Better training, processes and protocols could be developed through a sustained exchange between domestic violence workers and mental health services, a collaboration which is vital for enhanced care. Battered women are ‘individuals with strengths, resources and spirit which often transcend desperate social circumstances’ (p.15). Consequently, health and domestic violence services should ‘acknowledge, affirm and encourage the strength, courage, perseverance, ingenuity and resilience of battered women’ (p.15). This strategy will be the most successful to help individual women make changes and a healing of their own. The book includes careful guidelines for assessment, including how to assess safety and the strengths women bring, and clinical approaches and methods for dealing with diversity (Gondolf 1998, p.14). The assessment and treatment of men who use violence is also

The table referred to in the text can not be reproduced due to copyright restrictions. The table summarises the differences between battered women’s and mental health services on the following dimensions: type of analysis (sociological vs. psychopathological); problem view (social problem vs. interactive family system); objective (safety and empowerment vs. mental stability and coherence); services provided (safety, resources, sanctions vs. medication, psychotherapy and hospitalisation); and social aim (institutional change and social reform vs. individual coping with stressors and adjustment to society). (Gondolf 1998, p. 7)
important when health services providers see both partners (Ferris et al. 1997; Gondolf 1998).

Warshaw (1997) argues that a new medical curriculum, including the following characteristics, is required for all medical professionals: recognition of individual and societal forces which generate and sustain abuse; contextual factors which mediate patients’ experiences of abuse and shape their options; and individual and systemic factors which shape providers’ responses. She explains the challenges, including a paradigm shift for medical practice, in dealing with complex social issues. She argues this includes confronting gender perspectives, personal trauma and experiences from both the student’s own life history and the impact of listening to survivors. She highlights the importance of understanding that a clinical focus can overlook the role of the clinical interaction in reinforcing or transforming the experience of abuse for victimised women. She outlines how education and support needs to be transformed to enable the collaborative partnerships for women’s care, which she also supports.

Helping individual women

In a previous Issues Paper (No.4) in the Australian Domestic and Family Violence Clearinghouse series, Laing (2001) described the problematic history and context for therapeutic interventions with women who had experienced violence and abuse. She found that there were difficulties, from within a feminist framework, to using an individual therapeutic response when the problem was located within an unjust and unresponsive system. She cites Carlson, who identified four concerns with therapy: first that counselling may imply the woman has personality deficits; second that counselling may perpetuate victim-blaming and obscure the perpetrator’s responsibility; third that the inherent power imbalance between therapist and patient may replicate that in the abusive relationship; and fourth that the focus should more properly be on changing the wider system (Laing 2001, p.1). She outlines how current intervention options strive to manage these sometime competing perspectives in order to help the complex range of women who have experienced and responded to violence and abuse in many differing ways.

Laing discusses the value of group work and individual trauma-based approaches. In keeping with the arguments proposed in this paper for the social model of health and the ecology of abuse, she cites Dutton (1992) who emphasised the importance of undertaking a careful history to elicit ‘the nature and pattern of the abuse women experience, its psychological effects, the woman’s survival strategies and the wider ecological factors which ‘mediate both the effects of the abuse and the survival strategies used to respond to it’ (Laing 2001, p.8). Similarly, she quotes Herman’s therapeutic goals of ‘recovering safety, reconstructing the trauma story and restoring the connection between the survivors and the community’ (Herman 1992, p.3). Herman’s is one among several models which acknowledge the wider contexts of abuse and address the power imbalance between therapist and woman.

Stark and Flitcraft (1996) extend Herman’s trauma model and presume an inadequate and unresponsive system. They propose a ‘dual trauma’ of coercive control exercised by the perpetrator and inadequate institutional interventions, which must be tackled in any therapeutic response. Harvey (1996), on the other hand, moves beyond any clinical responses to emphasise other environmental contexts and the importance of community, rather than clinical intervention to foster resiliency.

Frasier et al. (2001) and Burke et al. (2001) outline how the Transtheoretical or Stages of Change model can be useful to counsel women victims/survivors. This model describes a pathway from Pre-contemplation of the problem, to Contemplation, Decision, Action, Maintenance or Relapse. It can help health service providers understand where an abused woman is located along this continuum of acknowledging abuse and readiness to change and therefore how to work with her (Burke et al. 2001; Frasier et al. 2001). Further therapeutic models include safety planning, a risk management model (Shaw et al. 1996), care pathways (Miller et al. 2002) and narrative therapies (Laing 2001). Very recently, in keeping with the evidence outlined in this review, Dienemann et al. (2002) used the Landenburger theory of entrapment and recovery to develop a domestic violence survivor assessment (DVSA) tool. This process has empowerment as its goal. The authors claim that the DVSA will assist counsellors to understand the woman’s reality and help guide her to better understanding her situation and her options.

Some therapeutic models may include controversial counselling for women who wish to remain with their partner and which includes the man. The dilemma in these models centres on how best to assess the type and form of violence and abuse and the lethality of the man, therefore the safety of the woman and the effectiveness of therapy (Goldner 1992; Bograd 1994; Bograd & Mederos 1999; Goldner 1999; Lundy & Grossman 2001). This conjoint counselling could only be used with professional therapists specially trained in domestic violence, as the debate is unresolved within the therapeutic community and would not be appropriate for other health providers such as GPs, mental health or drug and alcohol counsellors.

Paradoxically, while interventions with children and men are well evaluated, the same is not true
As the complexity of partner abuse becomes clearer...the relevance of integrating theoretical approaches in therapeutic intervention becomes more pressing. Domestic violence workers and clinicians can both offer support to women, which should be coordinated.

For interventions with women, Abel (2000) recently reviewed the effectiveness of psychosocial treatments for battered women and found only nine studies which attempted to evaluate psychosocial treatment interventions. The findings of these studies, which evaluated refuge services, single and group interventions, advocacy services, support groups, brief counselling and follow-up, were inconsistent. Abel concluded however, that the evaluation methods were limited. Only one used a comparison group, most were short term, brief interventions and most used inexperienced workers. She reports honestly that while six of the nine indicated client improvement, care should be exercised in generalising because of the many study limitations, such as the use of convenience samples. This points out that abused women who choose to participate in the study may be different from abused women who do not participate or who drop out. Most of the treatments use a feminist theoretical perspective and combine social support, social and economic theory and cognitive or cognitive behavioural frameworks. Abel argues for more attention to longer-term follow-up with women to ascertain that the effectiveness and benefit of treatment is retained for women over time.

Lundy and Grossman (2001) comprehensively reviewed research about the treatment of battered women. They concluded that the effectiveness of interventions is neither well researched nor well understood. The little research that has been done does not reflect integrated models and the authors suggest that this may be because of the distrust between clinicians and domestic violence workers. As the complexity of partner abuse becomes clearer, they argue, the relevance of integrating theoretical approaches in therapeutic intervention becomes more pressing. Domestic violence workers and clinicians can both offer support to women, which should be coordinated.

Lundy and Grossman found that while there has been a growing number of studies evaluating the effects of psychotherapy, for example, very little of this has been explicitly with women experiencing domestic violence. In discussing a review of treatment for PTSD, they note that this only addressed Vietnam veterans and rape victims, and suggested that this may be because so few mental health services identify partner abuse among their clients, and women may be seeking help for the symptoms and not disclosing the abuse. They identified one review of support group studies (Tutty 1996) with limited designs, small numbers in the sample, none randomised, few with comparison groups. However three showed some important differences in pre- and post-test gains made by women in outcomes such as self-esteem, anger and depression. Other studies of groups and couple counselling they review find no differences in outcomes. The authors raise problems for clinical research, such as using a reduction of violence, which is not usually under the woman’s control, as the outcomes measure. Further, because abused women feel unsafe, they are often highly mobile, hence difficult to include in research studies. Lundy and Grossman note the need for research on culturally and linguistic differences, especially among immigrant and refugee women, whose needs at a broader level may be much more complex.

Where domestic violence advocacy (at individual and systems level) is better evaluated, using comparison groups, these have shown clear differences. McFarlane’s and Sullivan’s studies, both using large samples and community advocates, demonstrated small but clear gains in safety behaviours, social support and quality of life (McFarlane et al. 1997, 1998; Sullivan & Bybee, 1999). Lundy and Grossman emphasise the importance of women’s self evaluation and in one study, women highlighted different forms of help depending on what form of violence they experienced. For example, among emotionally abused women, a focus on self-esteem was valued, whereas if they experienced physical abuse, confronting the danger was more important. The study pointed out however, that for all women, respectful listening and belief in their stories was regarded as the most helpful professional response. In a concluding overview, Lundy and Grossman (2001) argue for integrated and collaborative treatments (clinical and advocacy) at all levels of Heise’s ecological model and for rigorous evaluation of these levels of interventions, from the individual outwards to the community and society.

Conclusion

This paper has reviewed the evidence for the global prevalence of intimate partner violence and the strong links between intimate violence against women and the consequent damage to their mental health. Such damage includes depression and anxiety, drug and alcohol misuse, suicidality and especially post-traumatic stress disorder. The pattern of mental health damage is repeated around the world, across many societies. While wider violence within countries and cultures may
exacerbate the differences, a gendered risk of violence to women's mental ill health is clear. The severity of the disorders is shaped by the types of violence women experience, and how long and how often they have been inflicted.

The history of explanations for, and responses to, women's mental ill health has been profoundly shaped by the location of such explanations within the women themselves, rather than with their partners who abuse them. Until recently, these explanations and responses did not attend to the wider patterns of discrimination reinforcing beliefs and behaviours.

What is needed is a health system in which professionals have a high index of suspicion about partner abuse and other forms of violence among women presenting with symptoms of trauma and health professionals who ask wide-ranging and open questions about the context and causes of women's trauma. When responses to women's mental disorders are not shaped by these understandings, they can be further damaging, as they remain at the level of the individual, when wider forces and institutional inadequacies limit her capacity to change. This may require a paradigm shift in health professional education and institutions. It would incorporate enhanced collaboration with all community-based services that respond to intimate violence and models that include empowerment and social support.

Promoting women's mental health will best be done within societies where such gender discrimination is proscribed and reinforced by healthy public policies which promote gender equality and promote a zero tolerance of violence against women. Within such a system, women will feel free to disclose any partner violence and abuse, confident that the well-trained and supported professional to whom they tell their story will listen, hear and believe them. These professionals, confident and well-resourced, will understand and elicit the full context of the violence the woman is experiencing, so that together with advocates in the community, any intervention they make will be informed by, and in partnership with, actions at the community and society level. Health promoting responses such as these will not only reduce the trauma and harm the woman has experienced, but bring wider benefits to her health and that of her family, community and country.

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The table on page 17, from Gondolf (1998) Assessing Woman Battering in Mental Health Services, is reprinted with the kind permission of Sage Publications, Inc.

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## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Advocates</td>
<td>A person who pleads a case on someone else’s behalf, a term used overseas for domestic violence workers.</td>
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<tr>
<td>Benzodiazepines</td>
<td>Medicine: any of a class of heterocyclic organic compounds used as tranquillisers.</td>
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<td>Borderline Personality Disorder</td>
<td>A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity.</td>
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<td>Co-morbidity</td>
<td>The co-existence of two disorders in any one person at the same time, eg anxiety and depression.</td>
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<td>Disease burden, also known as the burden of disease</td>
<td>Rates of disease and sometimes mortality or death rates as a result of the disease in a given population.</td>
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<td>Disengagement</td>
<td>Emotional detachment or un-involvement.</td>
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<td>Dissociation</td>
<td>The separation of normally related mental processes, resulting in one group functioning independently from the rest and leading to disorders such as multiple personality (dissociative identity disorder).</td>
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<tr>
<td>Dysthymia</td>
<td>Persistent mild depression.</td>
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<tr>
<td>Epidemiology</td>
<td>The study of the distribution and determinants causes of health-related states or events in specific populations and the application of this study to control of health problems.</td>
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<td>Masochism</td>
<td>The tendency to derive pleasure, especially sexual gratification, from one’s own pain or humiliation.</td>
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<tr>
<td>Neurosis</td>
<td>A relatively mild mental illness not caused by organic disease, involving depression, anxiety, obsessive behaviour, etc but not a radical loss of touch with reality.</td>
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<tr>
<td>Patriarchy</td>
<td>A system of society or government ruled by men.</td>
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<tr>
<td>Personality disorder</td>
<td>A deeply ingrained and maladaptive pattern of behaviour, typically causing long term difficulties in social relationships.</td>
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<td>Phobia</td>
<td>An extreme or irrational fear of something.</td>
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<td>Post-traumatic stress disorder PTSD</td>
<td>A condition of persistent mental and emotional stress occurring as a result of injury or severe psychological shock.</td>
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<td>Psychopathology</td>
<td>Features of people’s mental health or mental health disorders considered collectively.</td>
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<td>Social ecology</td>
<td>A social ecology is a study of the surrounding social conditions which can impact on health, such as poverty, poor housing, a violent subculture, racism and xenophobia etc and which can also impede recovery.</td>
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<tr>
<td>Somatisation</td>
<td>The production of recurrent or multiple medical symptoms with no discernable organic cause.</td>
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