

Women, Domestic Violence, and Posttraumatic Stress Disorder (PTSD)*

by

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TABLE OF CONTENTS

TABLES.....	4
EXECUTIVE SUMMARY.....	5
POLICY AND PROGRAM RECOMMENDATIONS.....	6
SUMMARY OF EMPIRICAL GENERALIZATIONS FROM THE LITERATURE.....	7
SUMMARY OF ACTION GUIDELINES FOR INTERVENTION.....	7
INTRODUCTION.....	9
RESEARCH QUESTIONS ADDRESSED BY THIS REPORT.....	10
METHODOLOGY.....	11
SYSTEMATIC RESEARCH SYNTHESIS.....	11
Steps in SRS.....	12
SRS Findings.....	13
Limitations of the Research.....	13
Empirical Generalizations.....	15
Empirical Action Guidelines.....	23
A General Statement about PTSD and Domestic Violence Intervention.....	23
Macro Level Interventions.....	23
Mezzo Level Interventions.....	26
Micro Level Interventions.....	27
Survey Findings.....	32
Limitations of the Survey.....	32
Recommendations for Mental Health Service Delivery Based Upon Survey:.....	33
Methodology.....	33
Findings.....	34
Model Programs.....	38
REFERENCES.....	41
APPENDIX A.....	49
APPENDIX B.....	50
APPENDIX C.....	68

LIST OF TABLES

Table 1: Additional Mental Health Problems in Victimized Women.....	19
Table 2: Effect of Demographic Variables on Mental Health Symptoms Including PTSD.....	21
Table 3: Mental Health Strategies Recommended in the Literature Reported Upon.....	29
Table 4: Domestic Violence Arrests, 1988-1998	31
Table 5: Cultural/Ethnic Diversity of Clients.....	35
Table 6: Treatment Strategies Used by Programs	36
Table 7: Effective Strategies for Treating PTSD Symptoms in Domestic Violence Victims	37

EXECUTIVE SUMMARY

Domestic violence, if considered a disease, would be declared a national epidemic based on the magnitude of its incidence. In the United States each year, intimate partners batter between two and four million women of all ages, races and classes. Among women of different racial and ethnic backgrounds, the difference in the prevalence of reported rape and physical assault is statistically significant.

Posttraumatic Stress Disorder (PTSD)¹ has been diagnosed most commonly in rape, child sexual abuse, and war victims. More recently, studies have found battered women meet the criteria for PTSD. The severity of the violence, the duration of exposure, early-age onset, and the victim's cognitive assessment of the violence (perceived degree of threat, predictability, and controllability) exacerbate the symptoms.

The project had multiple objectives. The first was to compile and analyze data from professional literature that was based on studies of battered women to determine (a) the correlation of domestic violence and PTSD, (b) the best treatment strategies for PTSD, and (c) the evidence of PTSD treatment effectiveness with battered women. The project used Systematic Research Synthesis (SRS), a meta-analysis process, to analyze data collected from the most current literature on domestic violence and its correlation with PTSD. A second objective was to determine what we know about the number of women experiencing domestic violence in the State of California and what happens to these women in the aftermath of their experience. A survey sent to all 58 Directors of County Mental Health Departments was used to compile data about these women. A third objective was to identify model programs in the State of California. The questionnaires to County Directors and information gathered from programs throughout California were used to meet this objective. Lastly, the policy and program implications of the study were concluded.

Analysis of reliable studies from the literature and survey results produced several important findings: (a) symptoms of battered women are consistent with PTSD symptoms, (b) certain populations are at higher risk of developing PTSD symptoms, (c) intensity, duration, and perception of the battering experience is a significant factor in the severity of the women's PTSD symptoms, (d) some demographic variables have an influence on PTSD severity, (e) there is a need for standardized PTSD assessment by trained professionals working with domestic violence women, (f) there is a need for greater public health involvement for prevention, identification, and medical treatment of domestic violence and PTSD, (g) certain treatment strategies have been found to be best practices in working with battered women with PTSD, (h) few public agencies in California responding had programs specific to domestic violence women, (i) most treatment is on an outpatient basis, and (j) assessment, emergency services, support groups, substance abuse, and case management were the most commonly used treatment strategies.

¹ The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines PTSD: "The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving actual or threatened death or serious injury, or other threat to one's physical integrity..."

POLICY AND PROGRAM RECOMMENDATIONS

Ten policy and program recommendations emerged from the project. They are as follows:

- Most importantly, women experiencing domestic violence, PTSD, or both must be treated in a way that validates their experiences (both past and present), validates their symptoms through both individual counseling and support groups, and gives them problem solving skills to overcome their battering and achieve a safe and healthy lifestyle for themselves and their children.
- Whereas Battered Women Syndrome is subjectively defined and Posttraumatic Stress Disorder is objectively defined by the Diagnostic and Statistical Manual (DSM-IV), justices should be mandated to use the latter in determining cases in order to avoid wrongful determinations in cases in which the victim retaliated, whether lethally or otherwise.
- Sentences that send a strong message to batterers need to continue and become standardized as a protection for women and their children.
- A universally adopted instrument needs to be developed to assess for PTSD in symptomology, severity of abuse, frequency of abuse and severity of symptomology.
- Additional funding is needed for shelters to allow them the opportunity to hire professional staff with special training in PTSD and domestic violence assessment and treatment of domestic violence victims.
- Programs should adopt treatment methods shown to be effective through scientific studies for treating domestic violence victims with PTSD and investigation of model programs throughout the state and nation.
- Local, state, and national programs' record-keeping of women served needs to be standardized so that better data can be collected for research.
- More funded research is needed to test specific treatments for PTSD in conjunction with domestic violence women, and studies need to include cultural variables to determine if women from different cultural/ethnic groups respond differently to treatment modalities.
- Given that child abuse is significantly correlated with domestic violence, more funding to support home visitation programs, which treat the child (ren) as well as the battered women in homes where domestic violence is occurring, is needed.
- The public health approach for PTSD and domestic violence should be proactive in identifying domestic violence victims and offering information to women on a routine basis about prevention and treatment of domestic violence.
- Cross-system training for effective multi-disciplinary practice and coordination of services is needed since the problems of victimized women cross so many service systems.

SUMMARY OF EMPIRICAL GENERALIZATIONS FROM THE LITERATURE

1. Available research indicates that the symptoms exhibited by battered women are consistent with the major indicators of PTSD as currently defined by the DSM IV. A consistent finding across varied samples (i.e., clinical samples, shelters, hospitals, community agencies, etc.) is that substantial proportions of victimized women (31% to 84%) exhibit PTSD symptoms.
2. The domestic violence shelter population is at a higher risk for PTSD than victimized women who are not in shelters. Estimates of victimization among the shelter population range from 40% to 84%.
3. Having multiple victimization experiences (childhood abuse, particularly sexual abuse, and adult sexual abuse) increases the likelihood of PTSD and many other types of psychiatric disorders.
4. The extent, severity, and type of abuse are associated with the intensity of PTSD. Severity refers to how life threatening the abuse is. The more life threatening the abuse is, the more traumatic the impact. Sexual abuse, severe physical abuse, and psychological abuse are associated with an increase in trauma symptoms among victims. Women need not experience severe violence to experience PTSD symptoms; but experiencing severe violence exacerbates symptoms. Psychological abuse may be as damaging as physical violence.
5. Other forms of emotional distress accompany PTSD, particularly depression and dysthymia, are noted among domestic violence victims. A history of depression may be a risk factor for victimization.
6. Suicide is a risk among domestic violence victims who exhibit PTSD symptoms. PTSD may mediate the link between partner abuse and suicidal ideation.
7. Substance abuse was reported in a high percentage of victimized women. Women who reported being victims of child abuse and adult abuse had significantly more lifetime drug and alcohol dependence than women not reporting abuse.
8. In addition to PTSD, depression, and substance abuse, other mental health problems have been noted in victimized women.
9. The empirical evidence does suggest that younger unemployed women, with a relatively large number of children, with low income, and low levels of social support, are more at risk to experiencing PTSD symptoms and other mental health problems than women without those characteristics.

SUMMARY OF ACTION GUIDELINES FOR INTERVENTION

1. The high numbers of victimized women experiencing PTSD suggest it is a useful construct for use in treatment of battered women.
2. A public health prevention approach is needed for PTSD and domestic violence.
3. Screening for victimization should become a standard of mental health practice so referrals to appropriate agencies can be made.
4. Mental health outreach to the shelters seems warranted.
5. The treatment of substance abuse ought to be an integral part of the recovery from battering.
6. In addition to mental health services women would need additional concrete assistance (medical, financial, housing, child care, legal etc.).
7. Effective multi-disciplinary practice and coordination of services are needed with this population.
8. Medical personnel must ask women directly whether they have been abused. Both asking and reporting should be mandatory in all jurisdictions.
9. Low income and younger women, including teens, are especially vulnerable to abuse and symptoms. This vulnerability suggests they need to be the targets of prevention and treatment programs.
10. Support groups can provide a safe structure for the battered women.
11. Practitioners need assessment methods that accurately identify domestic violence, and they need to know how to develop intervention strategy that addresses the safety needs of victims.
12. It is important to assess a battered woman's family background for a history of psychological trauma and family dysfunction so that sources of potential vulnerability can be evaluated.
13. The research indicates that clinicians need to distinguish between severity (levels) and types of violence since the psychosocial effects of domestic violence will vary according to severity and type.
14. Skill training in alternative coping responses and problem solving is needed by abused women whose fear, depression, cognitive problems, and lack of social support make it difficult for the women to plan for their own safety.
15. Effective therapy for battered women offers a supportive relationship, focuses on the abuse, validates the women's perceptions, encourages self-determination, and provides a safe setting to work through the residue of years of trauma.
16. Domestic violence service providers, mental health staff, medical personnel and other relevant professionals need to be sensitized to the increased suicide risk noted among abused women with PTSD.
17. Cognitive-behavioral therapies are the most commonly recommended treatment strategies in the literature for PTSD.

INTRODUCTION

Partners are the predominant perpetrators of violence against women. In the United States each year intimate partners batter between two and four million women of all races and classes (First Comprehensive National Health Survey of American Women, 1993; Tjaden & Thoennes, 1998). It is estimated that 21% of adult women suffered sexual abuse as children; 20-25% of women are raped as adults; and 30-50% of married women suffer physical assaults by spouses (Plichta, 1996). Physical assaults involve punching with a fist, kicking, biting, beating, or attack with a gun or knife (Straus & Gelles, 1986). Current patterns predict that 50% of women will be victims of domestic violence at some point in their lives (Corsilles, 1994).

Every year in the United States, between 1500 and 4000 people die as a result of partnership violence (Corsilles, 1994; Straus & Gelles, 1988). Thirty-one to 42% of all female homicides are the result of domestic violence (Corsilles; Gross, 1997). Corsilles also reported that domestic violence is a primary reason for injuries to women. Assault by an intimate partner is the leading cause why women visit hospital emergency rooms (Zorza, 1992).

In California, the number of domestic violence arrests and rate per 100,000 in the general population has increased steadily from 1988 to 1997. The number of arrests declined 10.6% in 1998, which may indicate society's condemnation of this behavior and changes in how the legal system views domestic violence, the victims, and what constitutes an appropriate response by law enforcement and the courts (Lockyer, 1999).

The above statistics should indicate that domestic violence ought to be a major social policy concern. Despite the published data, exact counts of the extent of domestic violence are difficult to determine. Victims are often reluctant to report domestic violence due to a complex set of factors: fear, hope that their partner will change, lack of options, financial concerns, cultural factors, or pressure from others in their social network. Straus and Gelles (1986) asserted that only one in every

seven victims report the domestic violence being directed against them. Cases not directly reported by the victim are unlikely to be recorded elsewhere because medical, social service, and police personnel may fail to identify domestic violence or respond appropriately when they encounter it (Nurius, Hifrink, & Rifino, 1996).

The most common diagnosis by mental health professionals for battered women is Posttraumatic Stress Disorder (PTSD) (Crowell, 1996). However, the typical treatment strategies for battered women are not those developed for PTSD. Battered women are likely to be just treated for depression or some other psychological disorder. The mismatch of treatment with disorder might not only be ineffective but it may make matters worse.

This report examines previous research on this topic, and the actual treatment regimes employed in the State of California in order to develop suggestions on how state government could better assist in the treatment of PTSD that women experience after victimization from domestic violence.

RESEARCH QUESTIONS ADDRESSED BY THIS REPORT

1. What does the academic literature tell us about the PTSD syndrome for women as a result of domestic violence against them? What are the best treatment strategies for this condition? What evidence of treatment effectiveness (or lack thereof) is there for treating Posttraumatic Stress Disorder for women?
2. What do we know about the number of women experiencing domestic violence in the State of California, and what do we know about what happens in the aftermath of this experience?
3. What federal, state, or local government programs are currently designed to provide mental health services to women who have experienced domestic violence? Do any of them recognize Posttraumatic Stress Disorder and treat it? How might these be improved?
4. What mental health strategies are currently prevalent in treating these women? What evidence of treatment effectiveness do we have?
5. What do we know about mental health strategies that are effective in treating women who have experienced domestic violence? Are there model programs in California?
6. What are the policy and program implications of this work? Could the state design and implement policy that would assist in the more effective handling of this issue?

METHODOLOGY

Three separate means of data collection were utilized to answer the research questions. These were:

1. Systematic Research Synthesis (SRS) is a form of structured inquiry that uses structured protocols reflected in meta-analysis together with the integrative qualities of the traditional literature review. Meta-analysis is a quantitative form of the traditional qualitative literature review. It seeks to arrive at a common metric that incorporates multiple studies into a single statistic signifying the influence of an intervention on an outcome or dependent variable (such as PTSD).

SRS is used to “make sense” of massive and disorderly research evidence. The outcome is to create a conceptual synthesis of disparate research findings. The synthesis identifies where the consensus is in the literature on how to treat a particular phenomenon such as domestic violence. The goal of the synthesis is to develop empirical statements that would aid in the development of practice strategies as well as to accumulate new knowledge (Rothman and Thomas, 1994).

2. Existing on-line computer databases were used to gather data.

3. A mailed, self-administered survey was conducted of 58 County Mental Health Directors to answer some of the research questions concerning California.

Systematic Research Synthesis

SRS was used to answer the following sets of research questions:

- What does the academic literature tell us about the PTSD syndrome for women as the result of domestic violence against them? What are the best treatment strategies for this condition? What evidence of treatment effectiveness (or lack thereof) is there for treating post-traumatic stress syndrome for women?
- What mental health strategies are currently prevalent in treating these women? What evidence of treatment effectiveness do we have?

Steps in SRS

1. Identify specific data sources

Computerized databases, hard copy sources, and unpublished sources were all compiled for the SRS. The databases include Psychlit, Mental Health Abstracts, Social Work Research and Abstracts, Sociofile, and Medline.

2. Determine appropriate descriptors for the search

Research-based articles published in the last ten years reporting on domestic violence, PTSD, domestic violence treatment/intervention, domestic violence and mental health, cultural differences and domestic violence, domestic violence and welfare reform, domestic violence and undocumented women were all sought from the databases.

3. Establish procedures for codifying, assessing, and managing information

The procedures were used to abstract relevant data from the sources identified. A coding instrument was developed to guide our efforts. See abstract instrument in Appendix A. Each source was reviewed in systematic fashion to identify the following:

- Theme addressed (from descriptors, for example domestic violence and welfare reform)
- Study methodology (variables, social context, subjects, design, instruments use)
- Theoretical perspectives, conceptual framework, hypothesis
- Quality of study (evaluation of study methods, limitations, relationships to other studies, information used to weight study findings in relationship to the literature) Assessing a study for its appropriateness for inclusion in the synthesis pool included considering validity, reliability, sample representativeness, logic of the design, and match between the form of the data and the statistical techniques.
- If study is found to be scientifically sound, findings and implications for policy were recorded. Studies were weighted according to the strength of the research design. For

example, probability samples were given more weight than non-probability samples.

Appendix B provides a summary of the studies included in this report.

4. *Establishing procedures for developing consensus findings and intervention and policy guidelines.*

Uniformities and tendencies in the data were identified to form consensus findings called empirical generalizations. The synthesis process included:

- Intervening variables that explain or reconcile differences in findings between studies were identified.
- Consensus findings from disparate scientifically sound studies were generated called empirical generalizations; synthesis entails the creation of new concepts, or modification, or reorganization of current ones.

Action guidelines parallel the consensus findings and are a restatement that emphasizes the practice, policy, and program implications of the findings that were identified.

SRS Findings

Limitations of the Research

Forty-two studies published in the last ten years on PTSD and domestic violence were identified and included in this report. Several other studies were identified and discarded as empirically weak. It is important to note that the concept of trauma-related mental illness goes back as far as the American civil war, having been called such things as shell shock and battle fatigue. However, the recognition by the mental health community of PTSD is quite recent. PTSD was first introduced as a diagnostic category in the third edition of the Diagnostic and Statistical Manual of Mental Disorders published in 1980 (Roth & Coles, 1995). The newness of PTSD as a formal disorder has meant that rigorous efficacy and effectiveness studies of treatment of PTSD are lacking. This deficit in the research is even more acute with victims of domestic violence (Foa & Meadows, 1997). However, there is a literature that has developed over the last decade that describes PTSD with battered women, and some researchers have begun to explore the treatment of PTSD in battered women. This literature does

allow us to reach some conclusions about the nature of PTSD in battered women, and preliminary suggestions for treatment can be inferred from those conclusions. These suggestions should be accompanied by field-testing. The following is a discussion of some of the limitations of that research.

The samples of battered women who are studied are almost exclusively made up of women who came forward and sought help or shelter. These samples are probably not representative of battered women. They might be the most troubled of battered women, who sought help because of their distress; or they may be the healthiest of battered women, who still have the resources to seek services. The most distressed may not have requested help because they are immobilized. Depending upon the formulation of who the current samples represent, the psychological distress of battering may be over or underestimated.

Samples, for the most part, with some notable exceptions, are small, nonrandom, and drawn from a single site. Not all studies use comparison groups, and those that do often assess only differences between battered and nonbattered women without controlling for other possible controlling factors. The ability to generalize from studies is limited. Only one study compared the victims of domestic violence with other violent crime victims. The failure to compare victims of domestic violence with women assaulted by strangers reinforces the idea that partner violence is inherently different from criminal assault (Riggs, Kilpatrick, & Resnick, 1992). Some writers ask whether the research captures the minority or the middle-class experience. Available studies are disproportionately made up of white low-income or middle-class women. Studies also tend to be retrospective in nature rather than longitudinal, which limits determining the temporal ordering of effects. Further, since most studies chose their samples from among distressed battered women, the method of sample selection is likely to confound the relationship between PTSD and battering. Imprecise and different definitions of violence and psychological distress have also been a problem. The evidence offered to date has been largely clinical and descriptive in nature. Research in the last 10 years has made great strides. It has

empirically verified the assertions of clinicians of PTSD in domestic violence victims, and has described various other forms of distress.

Rubin reported in 1991 that there was limited support for the various interventions provided to battered women. The situation has not changed much in the last decade. While assessment has been studied extensively, the longitudinal course of PTSD and its treatment effectiveness has not been addressed. As of yet, the literature has not turned to efficacy practice research with domestic violence victims. Carlson and colleagues (1998) asserted that despite the clinical and social impact of PTSD in a variety of problems (combat, torture, natural disaster, child abuse, etc.), there are few controlled studies investigating its treatment. Foa and Meadows (1997) in a literature review of controlled studies on the PTSD treatment with a variety of populations (veterans, rape victims, childhood sexual abuse) suggested the research only allows us to draw preliminary conclusions. Pfefferbaum (1997) drew the same conclusion from a review of 10 years of PTSD treatment in the children's literature. Most researchers do provide suggested practice and policy implications from the descriptive research, which are reported in the paper. However, these implications are no substitute for field tests with randomized clinical trials.

Empirical Generalizations

What does the academic literature tell us about PTSD for women as a result of domestic violence against them?

The generalizations reported below represent the consensus findings. Studies supporting a generalization are reported with the consensus finding.

- 1. Available research indicates that the symptoms exhibited by battered women are consistent with the major indicators of PTSD as currently defined by the DSM IV. A consistent finding across varied samples (i.e., clinical samples, shelters, hospitals, community agencies, etc.) is that a substantial proportion of victimized women (31% to 84%) exhibit PTSD symptoms.*

(Astin, Lawrence. & Foy, 1993; Cambell, 1989; Cascardi, O'Leary, Lawrence, & Sclee, 1995; Duncan, R; Saunders, B.; Kilpatrick, D.; Hanson, R.; & Resnick, 1996; Dutton, Burghardt, Perrin, Chrestman, & Halle, 1994; Dutton & Painter, 1993; Follette, Polusny, Bechtle, & Naugle, 1996; Gleeson, 1993; Hattendorf, Ottens, & Lomax, 1999; Housekamp & Foy, 1991; Kalil

Rosen, Gruber, & Tolman, 1999; Kemp, Rawlings, & Green, 1990; Khan, Welch, & Zillmer, 1993; O'Keefe, 1998; Perrin, Van Hassalt, Basilio, & Hersen, 1996; Rollstin & Kern, 1998; Roth, Newman, Pelcovitz, der Kolk, & Mandel, 1997; Roberts, Lawrence, Williams, & Raphael, 1998; Rollstin & Kern, 1998; Rosen, 1999; Saunders, 1994; Thompson, Kaslow, Kingree, Puett, Thompson, & Meadows, 1999; Vitanza, Vogel, & Marshall, 1995; and West, Fernandez, Hillard, Schoof, & Parks, 1990)

An expansion of research utilizing standardized measures in the last 10 years to assess for the presence of PTSD has documented its presence. A national sample of adult women was screened for a history of serious assault in childhood, major depressive episode, posttraumatic stress disorder, and substance abuse. Women who reported partner abuse experienced more lifetime and current episodes of depression, posttraumatic depression, and substance abuse (Duncan, Saunders, Kilpatrick, Hanson, & Resnick, 1996). One study compared women receiving welfare with a sample of women not on public assistance. Thirty-nine percent in the sample who reported a recent incidence of violence had PTSD symptoms. However, the rate of women exhibiting symptoms was almost four times higher in the welfare group than in the nonwelfare group. Nineteen percent of women whose partners had victimized them at any time during their lifetime exhibited PTSD symptoms. The rate of symptomatology among nonvictimized women in the sample was 5% (Kalil, et al., 1999). These data suggest implications for welfare reform since victimized mothers may need treatment to remain in the workforce.

PTSD is a normal reaction to abnormal events. The diagnosis occurs most commonly as a stressful reaction to a catastrophic event involving actual or threatened death/injury. Symptoms include increased physiological arousal, persistent re-experiencing of the trauma (intrusive thinking), trouble sleeping, irritability, trouble concentrating, being watchful, arousal, feeling jumpy, fear, avoidance, hypervigilance, irritability, and psychic numbing including dissociation. There is no support for the belief that violence toward women that is perpetrated by their husbands is less traumatizing than violence by others.

2. *The domestic violence shelter population is at a higher risk for PTSD than victimized women who are not in shelters. Estimates of victimization among the shelter population range from 40% to 84%.*

(Gleeson, 1993; Khan, Welch, & Zillmer, 1993; O'Keefe, 1998; Kalil, Rosen, Gruber, & Tolman, 1999; Roth, Newman, Pelcovitz, der Kolk, & Mandel, 1997; Roberts, Lawrence, Williams, & Raphael, 1998; Rollstin & Kern, 1998; Rosen, 1999; Saunders, 1994; Scott-Gliba, Minne, & Mezey, 1995; Thompson, Kaslow, Kingree, Puett, Thompson, & Meadows, 1999; Vitanza, Vogel, & Marshall, 1995; and West, Fernandez, Hillard, Schoof; & Parks, 1990)

A high prevalence of psychiatric problems, including PTSD, is found among shelter populations.

Not only have they been battered but they are also “homeless.” They may lack other forms of social support, and they disproportionately have low income. Women who receive shelter services are in crisis. The precipitating violent event is rarely the only time these women have sustained violence (Dutton, 1992). PTSD could be expected in response to earlier acts of violence that culminated in the women's decision to leave home and seek shelter (Vitanza, et al., 1995).

3. *Having multiple victimization experiences (childhood abuse, particularly sexual abuse, and adult sexual abuse) increases the likelihood of PTSD and many other types of psychiatric disorders.*

(Astin, Ogland, Coleman, Foy, 1995; Astin, Lawrence. & Foy, 1993; Cascardi, O'Leary, Lawrence, & Sclee, 1995; Duncan, R; Saunders, B.; Kilpatrick, D.; Hanson, R.; & Resnick, 1996; Dutton, Burghardt, Perrin, Chrestman, & Halle, 1994; Follette, Polusny, Bechtle, & Naugle, 1996; Hattendorf, Ottens, & Lomax, 1999; Nuruis, Furrey, & Berliner, 1992; Rosen, Gruber, & Tolman, 1999; Roberts, Lawrence, Williams, & Raphael, 1998; Roth, Newman, Pelcovitz, der Kolk, & Mandel, 1997; and West, Fernandez, Hillard, Schoof;, & Parks, 1990)

Symptoms of recent traumas may not only be distressing in themselves, but they may also exacerbate symptoms related to earlier victimization. Exposure to multiple types of trauma experiences affects a person's rate of recovery from subsequent traumatic events (Follette, et al., 1999). Early trauma may be especially damaging because it may interfere with the mastering of developmental tasks, and place the person at greater risk to subsequent trauma.

4. *The extent, severity, and type of abuse are associated with the intensity of PTSD. Severity refers to how life threatening the abuse is. The more life threatening the abuse is, the more traumatic the impact. Sexual abuse, severe physical abuse, and psychological abuse are associated with an increase in trauma symptoms among victims. Women need not experience severe violence to experience PTSD symptoms; but experiencing severe violence exacerbates symptoms. Psychological abuse may be as damaging as physical violence.*

(Astin, Lawrence. & Foy, 1993; Cascardi & O'Leary, 1992; Hattendorf, Ottens, & Lomax, 1999; Housekamp & Foy, 1991; Khan, Welch, & Zillmer, 1993; O'Keefe, 1998; Rollstin & Kern, 1998; and Vitanza, Vogel, & Marshall, 1995)

The collective research suggests that the intensity of exposure to violence is a major factor in the development of PTSD in victimized women. This relationship has been found with combat veterans and rape victims (Butler, Foy, & Snodgrass, 1988).

5. *Other forms of emotional distress accompany PTSD. A high prevalence of mental disorders, particularly depression and dysthemia, are noted among domestic violence victims. A history of depression may be a risk factor for victimization.*

(Andrews & Brewin, 1990; Bergman & Brismas, 1991; Cambell, 1989; Cascardi, O'Leary, Lawrence, & Sclee, 1995; Cascardi & O'Leary, 1992; Follingstad, Brennan, Hause, Polleck, & Rutledge, 1991; Gelles & Harrop, 1989; Gleeson, 1993; Kalil, Rosen, Gruber, & Tolman, 1999; Kemp, Rawlings, & Green, 1990; Launius & Jensen, 1987; Riggs, Kilpatrick, & Resnick, 1992; Roberts, Lawrence, Williams, & Raphael, 1998; Rosen, 1999; Saunders, 1994; Scott-Gliba, Minne, & Mezey, 1995; Thompson, Kaslow, Kingree, Puett, Thompson, & Meadows, 1999; Varvaro, 1991; Vitanza, Vogel, & Marshall, 1995; and West, Fernandez, Hillard, Schoof, & Parks, 1990)

A consistent finding across varied clinical samples (i.e., women in a shelter, those seeking services from community agencies, and victimized women in the community) is that abused women have elevated symptoms of depression at the time of assessment. Depression as a correlate of PTSD was strongly supported as it has been in studies of Vietnam veterans (Silver & Iacono, 1984) and other PTSD populations (Armsworth, 1984; Krupnick & Horowitz, 1980; Titchner & Knapp, 1976). A common criticism of clinicians unfamiliar with PTSD is that they will overlook the trauma and treat the depression only.

6. *Suicide is a risk among domestic violence victims who exhibit PTSD symptoms. PTSD may mediate the link between partner abuse and suicidal ideation.*

(Bergman & Brismas, 1991; Kalil, Rosen, Gruber, & Tolman, 1999; Scott-Gliba, Minne, & Mezey, 1995; Thompson, Kaslow, Kingree, Puett, Thompson, & Meadows, 1999; and Vitanza, Vogel, & Marshall, 1995)

PTSD has been shown to be strongly associated with suicidal behaviors (Bullman & King, 1994; Davidson, Hughes, Blazer, & George, 1991; Kramer, Lindy, Green, Grace, and Leonard, 1994; Rudd,

Dahm, & Rajab, 1993; Warshaw, Massion, Peterson, Pratt, & Keller, 1995). Data from a probability sample in North Carolina (N=2,985) indicated that PTSD sufferers were 15 times more likely than nonsufferers to have attempted suicide (Davidson, et al. 1991).

7. *Substance abuse was reported in a high percentage of victimized women. Women who reported being victims of child abuse and adult abuse had significantly more lifetime drug and alcohol dependence than women not reporting abuse.*

(Bergman & Brismas, 1991; Duncan, Saunders, Kilpatrick, Hanson, & Resnick, 1996; Gleeson, 1993; Kalil, Rosen, Gruber, & Tolman, 1999; Roberts, Lawrence, Williams, & Raphael, 1998; West, Fernandez, Hillard, Schoof, & Parks, 1990)

Douglas (1987) interpreted the use of alcohol as an effort by battered women to self-medicate their anxiety. None of the researchers assert a causal relationship between substance abuse and battering, but they do note that there is a strong association.

8. In addition to PTSD, depression, and substance abuse, other mental health problems have been noted in victimized women, such as but not limited to:

Table 1: Additional Mental Health Problems in Victimized Women

<i>Cognitive difficulties</i>	(Kemp, Rawlings, & Green, 1990; Riggs, Kilpatrick, & Resnick, 1992; Saunders, 1994; Vitanza, Vogel, & Marshall, 1995)
<i>Somatization</i>	(Bergman & Brismas, 1991; Follingstad, Brennan, Hause, Polleck, & Rutledge, 1991; Roberts, Lawrence, Williams, & Raphael, 1998; Vitanza, Vogel, & Marshall, 1995)
<i>Anxiety Disorders</i>	(Kahn, Welch, & Zillmer, 1993; Roberts, Lawrence, Williams, & Raphael, 1998; Scott-Gliba, Minne, & Mezey, 1995; Rosen, 1999; Vitanza, Vogel, & Marshall, 1995)
<i>Phobias</i>	(Gleeson, 1993; Roberts, Lawrence, Williams, & Raphael, 1998; Saunders, 1994; Scott-Giba & Minna 1995; Vitanza, Vogel, & Marshall, 1995)
<i>Sleep Disorders</i>	(Kemp, Rawlings, & Green, 1990; Thompson, Kaslow, Kingree, Puett, Thompson, & Meadows, 1999)
<i>Fearfulness of Spouse</i>	(Cascardi & O'Leary, 1992; Wileman & Wileman, 1995)
<i>Obsessive Compulsiveness</i>	(Gleeson, 1993; Riggs, Kilpatrick, & Resnick, 1992)

The published research indicates that battered women show a significantly higher percentage of mental health difficulties than nonvictimized women. However, none of the studies claim a cause and effect relationship between being victimized and having a mental illness, but there is a strong associational relationship. All of the above symptoms are consistent with PTSD.

Cognitive problems include a tendency to have perception and memory failures and engage in ineffective and self-defeating problem solving (Vitanza, et al., 1995). Cognitive difficulties result from repeated batterings that lead to the development of perceptions that the victim is unable to successfully resolve her current life situation. The resulting sense of helplessness leads to increased feelings of depression, anxiety, and produces a debilitating effect on problem-solving ability. Obsessive compulsiveness is viewed as an effort on the part of women to defend themselves against anxiety through various repetitive activities (Gleeson, 1993).

Fear plays a crucial role in women's conditioning as victims. It is postulated that the more fear experienced, the more powerless a woman will become. Like victims of other trauma, women often identify with persons exercising power over them. This phenomenon is called traumatic bonding by Dutton and colleagues (1994) and is responsible for why many victims find it difficult to leave batterers.

Other problems noted have included permanent injury, hyperarousal (Saunders, 1994), psychoticism, paranoid ideation (Riggs, Kilpatrick, & Resnick, 1992), and psychosexual dysfunction (Gleeson, 1993). All of these problems are consistent with PTSD. Additional reported problems of battered women are that they are more likely to divorce, and to use more medical and mental health services than the general population (Bergman & Brismas, 1991). Two studies of women prisoners who killed their abusive partners experienced PTSD as a result of the victimization, which may have been related to the homicides (Hattendorf, Ottens, & Lomax, 1999; O'Keefe, 1998).

Stressed victims of domestic violence may also abuse their children. Walker (1984) reported that victims were more likely to hurt a child when battered than when they are safe. Straus (1983) reported

data from a nationally representative sample of 2143 families indicating that the more violent husbands are toward their spouses, the more violent the wife is to their children. Wives, who were victims of violence severe enough to be labeled as spousal abuse, had the highest rates of child abuse. Women who were subjected to what Straus describes as “minor violence” (pushes and slaps) had more than double the rates of physical assaults on children than did women not experiencing that kind of abuse. Victims may abuse out of stress from being battered. Holden and Richie (1991) report that battered women felt more highly stressed as parents than a control group of women who did not experience abuse. Jouriles and colleagues (1987) found in their research that parental aggression directed toward children was more likely to occur in families where domestic violence took place. The victim may be attempting to keep the children “in line” to avoid giving the perpetrator an excuse to batter.

9. *Studies that have examined the effect of demographic variables on PTSD and other mental health symptoms in victimized women have found for the most part they have little influence on symptoms except for the following:*

Table 2: Effect of Demographic Variables on Mental Health Symptoms Including PTSD

<i>Number of children in the home</i>	(Rollstin & Kern, 1998; Gelles & Harrop, 1989)
<i>Age of the women</i>	(Astin, Lawrence. & Foy, 1993; Gelles & Harrop, 1989)
<i>Family income or employment</i>	(Dutton & Painter, 1993; Gelles & Harrop, 1989; Nuruis, Furrey, & Berliner, 1992; Perrin, Van Hassalt, Basilio, & Hersen, 1996; Riggs, Kilpatrick, & Resnick, 1992; Thompson, Kaslow, Kingree, Puett, Thompson, & Meadows, 1999; West, Fernandez, Hillard, Schoof, & Parks, 1990)
<i>Social support</i>	(Andrews & Brewin, 1990; Finn, 1985; Perrin, Van Hassalt, Basilio, & Hersen, 1996; West, Fernandez, Hillard, Schoof, & Parks, 1990)

Despite the fact that none of the published research indicated that ethnicity is a factor in exhibiting PTSD, other research does indicate ethnicity is a factor in experiencing violence. One national representative probability sample (N=8,000) found that among women of different racial and

ethnic backgrounds, the difference in the prevalence of reported rape and physical assault is statistically significant. Native Americans were the most likely to report victimization. Hispanic women were less likely to report rape or physical assault than non-Hispanic women (Tjaden & Thoennes, 1998). Although the literature is sparse concerning African American women, Daly, Jennings, Beckett and Leashore (1995) suggested that they use different coping styles than their white counterparts that make them less likely to use some services such as shelters and counseling. More research is needed to determine how much of the difference can be explained by the respondent's willingness to report information to researchers, and how much is influenced by sociocultural factors (McGee, 1997). These findings would suggest that non-Hispanic and Native American women have a heightened risk of PTSD, but as yet no hard data exists to support that assertion. None of the reported studies of PTSD in the literature were designed to examine ethnic differences in the development of symptoms.

The empirical evidence does suggest that younger unemployed women, with a relatively large number of children, with low income, and low levels of social support, are more at risk to experiencing PTSD symptoms, and other mental health problems than women without those characteristics. The risk of battering is greatest from the teen years through the thirties. Low socioeconomic status (SES) is related to differential exposure to spousal abuse, with abuse being more prevalent in lower SES groups (Sorenson, Upschurch, & Shen, 1999 and Sullivan & Rumpitz, 1994). While domestic violence exists in all social classes, it is more prevalent among lower-income groups. An added cost of poverty may be an increased risk of violence against women. Studies have identified income as strong predictors of leaving or staying in an abusive relationship (Dutton & Painter, 1993 and Strube, 1988).

Other factors which may increase adverse reactions such as PTSD are having a traditional sex role orientation, witnessing the destruction of personal property (Follingstad, Brennan, Hause, Polleck, & Rutledge, 1991), attributions of self-blame for the victimization (Andrews & Brewin,

1990), poor health prior to victimization (Gelles & Harrop, 1989), single and not co-habiting (Thompson, et al); and experiencing other family stressors and negative life events (Astin, Lawrence. & Foy, 1993).

Empirical Action Guidelines

What does the academic literature tell us about treatment strategies for PTSD?

These guidelines represent consensus implications identified by the researchers cited above, or were inferred from the research by the authors of this report.

A General Statement about PTSD and Domestic Violence Intervention

- 1. The high numbers of victimized women experiencing PTSD suggest it is a useful construct for use in treatment of battered women.*

The trauma of battery, versus other symptoms, should be a central focus of intervention with abused women. Clinicians, who lack knowledge of the link between PTSD and domestic violence, may focus on the intrapsychic symptoms, and misinterpret symptoms as chronic psychopathology. This focus may not only be ineffective, but can feel like “blaming the victim” to survivors, and feed into feelings of worthlessness, and that they are “going crazy” (Saunders, 1994).

The PTSD construct is a simple and direct one with implications for helping victims understand the effects of trauma. The diagnosis may remove some stigma and self-blame by linking the women’s experience to other trauma victims, such as Vietnam veterans and disaster survivors (Kemp, et al., 1991). PTSD emphasizes that victims’ difficulties come from external sources (Saunders, 1994), and provides a diagnosis that is usually more benign than others, such as paranoid schizophrenia or personality disorder (Rosewater, 1985). Practitioners who share information with battered women on the prevalence and origin of PTSD may reduce anxiety and a sense of powerlessness arising from the disorder itself.

Macro Level Interventions

- 2. A public health prevention approach is needed for PTSD and domestic violence.*

Social and health policies directed at prevention of domestic violence and early intervention for both parent and child may relieve the longer difficulties identified in the literature. Education and intervention programs aimed at decreasing the level of family violence are likely to benefit the mental, as well as physical health, of victims and children. Primary prevention efforts might include public education about the association of domestic violence with adult mental health status. Secondary prevention would be aimed at health, social service, and community agencies that see victims of domestic violence. Providers of psychiatric and substance abuse services need to be aware of the possibility of domestic violence as a significant contributory factor to the current mental health problems (Roberts, et al., 1998). Professionals who work with domestic violence victims might benefit from training in treating trauma used in victim assistance with such problems as natural disasters, rape, torture, and war refugees (Gleeson, 1993). At the same time, practitioners must recognize the unique dynamics of domestic violence where victimization comes at the hand of intimate partners. Public policy makers need to be made more aware of the reality and costs of domestic violence. Tertiary prevention would involve careful screening of all women with mental health problems for domestic violence (Thompson, et al., 1999).

A domestic violence prevention program should reduce the cost of social service delivery. Women experiencing domestic violence need extensive social services including medical, mental health, legal, and economic assistance. There are also the hidden costs incurred when the violence is transferred to the next generation. An extensive literature has documented the mental health effects on children, including but not limited to (Echlin and Marshall, 1995; Hershorn & Rosenbaum, 1985; Hilburn & Munson, 1977, 1978; Holden & Ritchie, 1991; Kilpatrick & Williams, 1997; Levine 1975; Sternberg, et al., 1993). Exposure to domestic violence in childhood increases the likelihood that victims may become perpetrators, and victims of spousal abuse (O'Keefe, 1994, and Hien & Hien, 1998).

- 3. Screening for victimization should become a standard of mental health practice so referrals to appropriate agencies can be made.*

This guideline should not be interpreted as suggesting that all women with mental health problems have been victimized. It is just an added safety and diagnostic measure. With adequate screening, referrals to appropriate support services can be made.

- 4. Mental health outreach to the shelters seems warranted.*

Studies indicate that there is a high prevalence of what are ordinarily treatable mental health conditions among victimized women, particularly those in shelters. In addition, shelter staff should be trained in how to recognize PTSD symptoms, and how to make appropriate referrals.

- 5. The treatment of substance abuse ought to be an integral part of the recovery from battering.*
- 6. In addition to mental health services, women would need additional concrete assistance (medical, financial, housing, childcare, legal etc.)*
- 7. Effective multi-disciplinary practice and coordination of services are needed with this population.*

Domestic violence providers need to know about substance abuse, mental health, and child abuse issues. Substance abuse, mental health, and child protective service providers need to incorporate a focus on domestic violence into their interventions. They need to know how to assess for the presence of PTSD and how to make appropriate referrals. The number of services required for these families is daunting and may have overwhelmed many, especially given the fact they were almost certainly required to receive them from a variety of “specialty” providers, each of which most likely was not prepared to collaborate with the others in service delivery. Cross-disciplinary training on how to work together and coordinate service delivery is needed.

- 8. Medical personnel must ask women directly whether they have been abused. Both asking and reporting should be mandatory in all jurisdictions.*

A major recommendation of the literature is that medical services are key in the treatment of battered women since medical providers may be the first service providers to encounter battered women. Medical personnel must be aware of sources of help for abused women so they can make appropriate referrals. A viable alternative is to include social workers or other professionals trained in the diagnosis of family violence in hospitals, clinics, and shared practice (Bowker & Maurer, 1987; Tjaden & Thoennes)

9. *Low income and younger women, including teens, are especially vulnerable to abuse and symptoms. This vulnerability suggests they need to be the targets of prevention and treatment programs.*

Mezzo Level Interventions

10. *Support groups intervention can provide a safe structure for the battered women.*

Although both individual and group therapy have support in the literature, many therapists recognize a support group may be the only means of healing some battered women. They recommend that if a battered woman is in individual treatment, she also join a local support group (Dutton-Douglas, 1992 & Walker, 1989). Survivors of domestic violence may derive some comfort by meeting other survivors who can validate their symptoms as a common reaction to a terror-filled situation. Groups help provide social support to often isolated women with low levels of social support. Victim-only groups can help empower women, provide opportunities for skill building, help them come to grips with their experiences, and plan for the future (Housekamp, 1994; Saunders, 1994; Sclee, et al., 1998; Scott-Gliba, Minne, & Mezey, 1995; Varvaro, 1991; Wileman & Wileman, 1995).

Two studies of groups consisting of the victims with PTSD and batterers with mild-to-moderate aggression found women can benefit from group treatment with batterers. These studies asserted that the males' violence was reduced, as was the women's PTSD symptoms and sense of vulnerability. Both studies described group experiences that focused on male aggression. (Sclee. et. al., 1998;

Wileman & Wileman, 1995). Women with PTSD were not found to drop out of group treatment at a higher rate than women without PTSD (Sclee, et al., 1998).

Micro Level Interventions

11. The most common recommendation for practice in the literature is that practitioners need assessment methods that accurately identify domestic violence, and they need to know how to develop intervention strategies that address the safety needs of victims.

12. It is important to assess a battered woman's family background for a history of psychological trauma and family dysfunction so that sources of potential vulnerability can be evaluated.

Those working with the battered women must also be careful to pay attention to their history of relationships. Practitioners need to know how to intervene in relationships where violation of trust is an issue.

13. The research indicates that clinicians need to distinguish between severity (levels) and types of violence since the psychosocial effects of domestic violence will vary according to severity and type.

Domestic violence most often occurs over an extended period of time. This characteristic makes it much different from many other types of trauma. Child abuse and combat may be similar in their extension over time. In the past, women have been faulted for not walking away from the abuse sooner, and, therefore, symptoms have been minimized (Walker, 1984). The crucial link between exposure to the events of abuse provides an additional way of conceptualizing domestic violence that does not blame the victim (Housekamp & Foy, 1991). Familial child abuse may be a more similar trauma than combat because it occurs at the hand of intimates and in a supposed place of safety.

14. Abused women whose fear, depression, cognitive problems, and lack of social support make it difficult to plan for their own safety need skill training in alternative coping responses and problem solving.

There is a need to help women reconstruct their view of self (e.g., attitudes about themselves as worthy in their own right) as well as their capacity to assess risk and take protective action, and skills to get and keep sources of social support (Lauinas & Jensen, 1978; Nurius, Furrey, & Berliner, 1992). Empowerment is thought to be an outcome of strategies of teaching battered women to identify and attacking self-defeating cognitions with action and skill building (Gleeson, 1993).

15. Effective therapy for battered women offers a supportive relationship, focuses on the abuse, validates the women's perceptions, and encourages self-determination, and provides a safe setting to work through the residue of years of trauma (Housekamp, 1994 & Kemp, et al., 1991).

Practitioners need knowledge of the causes and contexts of domestic violence abuse in order that a nonjudgmental attitude toward the victim can be maintained; an understanding not only of the psychological foundations of family violence, but also the social structural stressors associated with violence. Therapy should focus on the trauma event, and help women obtain new skills to guarantee their safety. Inner-psycho theories that focus on such issues as why she chose an abusive partner are regarded as inappropriate and possibly damaging. Treatment for the underlying depression is also needed so that the women can mobilize resources on behalf of their own safety.

16. Domestic violence service providers, mental health staff, medical personnel and other relevant professionals need to be sensitized to the increased suicide risk noted among abused women with PTSD.

Suicidal women should be scrutinized for on-going intimate partner violence. Abused women should be questioned about active suicidal ideation and intent (Thompson, et al., 1999).

17. Cognitive-behavioral therapy treatment strategies are the most commonly recommended in the literature.

What follows is a description of the mental health strategies recommended by researchers reported upon in this paper, and a brief description of the research literature on treating PTSD in populations other than domestic violence. A discussion of their empirical support is included:

Table 3: Mental Health Strategies Recommended in the Literature Reported Upon

<u>Author</u>	<u>Population (1)</u>	<u>Description of Treatment</u>
Dutton-Douglas (1992) Recommended by Saunders (1994)	For women after the abuse has ended.	<p><i>Abuse-Focused Therapy.</i> The first phase stresses the importance of working through trauma. Included in this phase is the lessening of emotional numbing, and avoidance by naming the traumatic event, incorporating journaling, imagery, or bodywork, and developing strategies to deal with intrusive thinking. Relaxation techniques, stress management strategies, and emphasizing self-care are used to assist the women in coping.</p> <p>The second phase addresses symptoms associated with victimization. Symptoms are normalized. A critical aspect of this phase is intervening in the battered woman's identity.</p> <p>The third phase concerns changing dysfunctional cognitions. A critical aspect of this phase of therapy is to increase the battered woman's ability to distinguish what she can control (her own behavior) from what she cannot (her partner's violence).</p> <p>Finally, the battered woman needs to move on with her life, including developing strategies for maintaining good boundaries and identifying risks for future victimization. Couple counseling could be considered at this time if the partner has successfully completed a treatment program.</p>
Gleeson, 1993	Abused women with a history of depression	Psychotropic medication and individualized psychotherapy, or both. Competency training, assertiveness training, anger management, self-defense training, and vocational rehabilitation as approaches to the development of more positive attitudes, and the acquisition of more positive social skills.
Cascardi, et al. (1992)	Married victims	Cognitive-behavioral therapies modified for abuse histories and spousal abuse.
Mancoske, et al. (1994)	Voluntary service seekers	Individual counseling, following crisis intervention in general, improves self-esteem, self-efficacy, and

<u>Author</u>	<u>Population (1)</u>	<u>Description of Treatment</u>
		attitudes toward feminism. Initial counseling should focus on helping women grieve loss.
Lauinus & Jensen (1987)	White women, in their early 20's or 30's, and of average intelligence with middle-class income.	Problem-solving skill training as part of a repertoire of counseling and crisis intervention techniques.
Riggs, et al. (1992)	Women sexually assaulted by husband	Stress inoculation therapy that has proven effective with rape and other crime victims should be modified for spousal abuse victims.
Dutton, et al. (1994)	For women where cognitive failure is an issue with the abuse.	Cognitive-behavioral approaches addressing attributions (self-blame) women make about the cause of prior violence may prove useful for modifying negative core beliefs.
Nuruis, et al. (1992)	Women with abusive partners	Greater attention by practitioners to the coping capacity, consideration of different patterns through which stressors, appraisals of threat, coping resources may bear upon individual's ability to cope in ways which seen acceptable or adequate. Skill training in alternate coping responses needs to be combined with approaches that deal with depression and lack of social support in order to make it possible for women to operationalize their new skills.

1. Either the researcher said the treatment was for this population, or is a description of the researchers sample.

Cognitive-behavioral approaches seem to be the favored theoretical intervention with abused women and have been recommended for children exhibiting PTSD symptoms as a result of sexual abuse (Debinger, Lippmann, & Steer, 1996). It is also the treatment that has the most empirical support for treating PTSD victims in general (Foa & Meadows (1997). Other studies with PTSD patients have indicated that stress management and stress inoculation are effective in reducing short-term PTSD symptoms (Foa, et al., 1991; Foa, 1995). Nonbehavioral treatments have not been subjected to controlled investigations to the same extent as cognitive behavioral approaches. However, they could be just as effective or more so. Rigorous testing of them could demonstrate whether they are effective.

What do we know about the number of women experiencing domestic violence in the State of California?

The first part of this paper discussed why it is difficult to get accurate counts of domestic violence victims in California. What we do have are arrest rates for domestic violence, reported below. Arrests rates are an understatement of the problem.

Table 4: Domestic Violence Arrests, 1988-1998

1988					1998				
Gender	Percent of Population	# of Arrests	Percent of Total Arrests	Rate	Percent of Population	# of Arrests	Percent of Total Arrests	Rate	Percent of Change
Total	100.0	31,886	100.0	113.6	100.0	56,892	100.0	169.9	49.6
Male	49.9	29,982	94.0	211.5	50.2	47,519	83.5	282.7	33.7
Female	50.1	1,904	6.0	13.4	49.8	9,373	16.5	56.1	318.7
Notes									
Rates are based on annual population estimates provided by the Demographic Research Unit, California Department of Finance									
Rates were calculated by dividing the number of arrests by the respective population, then multiplied by 100,000									
Source: Lockyer (1999)									

The number of arrests for domestic violence rose steadily from 31,886 in 1988 to 63,636 in 1997, and then declined 10.6% in 1998 to 56,892. From 1988 to 1998, the domestic violence arrest rates increased 49.6% from 113.6 in 1988 to 169.9 (rates per 100,000 persons). During the time period reported above, domestic violence rates increased for Whites, African-Americans, and Others. The Other category increased the most (68.9%), from 51.2 per 100K in 1988 to 86.5 per 100K in 1998. African-Americans have the highest arrest rate at 472.6 per 100K in 1998, followed by Hispanics at 230.2 per 100K (Lockyer, 1998). About 75% of those arrested are between the ages of 18-39 with the modal number concentrated in the 25 to 29 year old age group (Lockyer, 1999).

The increase in arrests has its roots in state laws passed in the mid-1980's requiring that police treat all forms of domestic violence as criminal and that suspected abusers be arrested. These laws reversed previous practice of treating domestic violence as much less serious than other forms of violence. Perpetrators were seldom arrested unless an injury occurred and when charged were more likely to have a misdemeanor than felony (Leonard, 1999). More serious charges and mandatory arrest are seen as way to stop the violence.

The increase in the arrests of women disturbs some advocates for women as they see it as an indicator that the police are confused about who is responsible for the violence. If we use Straus and Gelles's formulation that only 1 in 7 domestic assaults are reported, there could be as many as 332,633 women assaulted by an intimate partner in 1998. Corsilles's (1994) data suggest that 50% of women will be victims at some point in their life. Straus and Gelles (1998) report data from a national probability sample suggesting a one-year rate of 16%.

Survey Findings

Limitations of the Survey

A limitation of this survey is that fewer than half of counties in California responded to the survey. We do not know what services are provided domestic violence victims in the counties that did not respond. Generally speaking, county mental health agencies do not provide specific services for domestic violence.

They rely on contract or not-for-profit agencies within their communities to provide services. However, most counties provide services for PTSD victims in general. Since the literature does suggest that there are unique features to trauma in domestic violence victims, the focus on PTSD by public mental health agencies in California may not meet the needs of domestic violence victims.

Recommendations for Mental Health Service Delivery Based Upon Survey

1. Public mental health workers should routinely assess for domestic violence as they do now for PTSD (see Action Guideline 3).
2. County public mental health agencies should collect data on the number of domestic violence victims served in the public sector. This would enable planners to accurately gauge the extent of the problem and identify the specific service needs of this population.
3. In-service training for public mental health workers should be directed at the following: (1) accurate assessment of domestic violence; understanding the nexus between domestic violence and PTSD; safety planning; and collaborative work with other providers whose service systems impact this problem. Secondly, training in cognitive-behavioral mental health strategies for those who treat domestic violence victims seem warranted.
4. Prevention strategies are needed (see Action Guideline 2)
5. Outreach services to shelters are also needed (see Action Guideline 3).

What do we know about the number of women experiencing domestic violence in the State of California?

Methodology

A questionnaire (see Appendix C) was developed to gather data on domestic violence (DV) programs and the treatment strategies they use in California. The questionnaires were mailed to the Directors of the Mental Health Departments in the 58 counties with a cover letter explaining the intent of the study and requesting that they or an appropriate designee complete it for their county.

Some Directors completed the questionnaire at the Mental Health Department while others routed it to the appropriate program serving DV women.

After the initial group of responses was received, those counties not responding were contacted by phone and encouraged to complete and return the questionnaires. Duplicate questionnaires were faxed or mailed to several counties. The final response rate was 27 out of 58 (46.6%). The Director for one of the largest counties was unable to fill out the questionnaire but gave a narrative description of how domestic violence is handled in that county. He referred us to another director in the county's domestic violence agency; however, she also indicated that she was unable to complete the questionnaire.

Findings

Respondents were asked two questions related to the services they offer to women who experience domestic violence and PTSD. The first question asked if they had a mental health program *specific* to women experiencing domestic violence. The second asked if they had a mental health program for women experiencing PTSD, whether or not they also were experiencing domestic violence. A little less than one-third (32.1%, n = 9) indicated they had a program *specific* to domestic violence women; 92.9%, n = 26, indicated they had a program for PTSD women.

Of the nine counties that had a program *specific* to domestic violence, seven were able to give an approximate number of women served each year. One county had just begun to keep records of women served and another stated it had no record because domestic violence clients were served through a victim witness program in the county's Social Services Agency. The range of 12 to 6,608 with a median of 85 may indicate either variance in the size of the counties or the number of domestic violence programs run by the county. Those respondents who reported the number of women served were asked what the ethnic breakdown was. Only four of the seven counties who kept records also kept the cultural/ethnic breakdown (see Table 4). Due to the small response to this question,

population conclusions cannot be drawn for California as a whole. There is an indication that record keeping of this information is needed across counties.

Table 5: Cultural/Ethnic Diversity of Clients

Culture/Ethnicity	County #1 n = 60	County #2 n = 20	County #3 n = 119	County #4 n = 800
White (nonHispanic)	95%		55%	30%
Hispanic	5%	98%	10%	51%
African Descent			20%	15%
Asian			10%	2%
Pacific Islander				1%
Native American			5%	1%

Respondents of both types of programs were given identical lists of mental health treatment strategies and asked to indicate which they used with their clients (See Table 5).

Given the suggestion in PTSD and domestic violence literature that many women victims of domestic violence go undetected for PTSD, it is beneficial that all respondents with programs *specific* to treating domestic violence victims use assessment as a strategy. This same literature also concludes the need to develop and use assessment instruments specifically designed to diagnose PTSD symptoms proven effective with domestic violence victims.

The low number of respondents using prevention strategies in PTSD programs is not surprising since the programs' clients are those who have already experienced the trauma. However, since the literature indicates that reoccurrence of traumatic experiences can increase the severity of PTSD symptoms in domestic violence victims as well as other trauma victims, using prevention as a strategy to reduce further domestic violence abuse is an option these programs should adopt. The high percentage of programs using outpatient treatment is expected since most cases are not severe enough to require hospitalization, which is the more expensive strategy of treatment. None of the respondents

in both program types used home-based or day treatment as a treatment strategy. The low percentage of programs *specifically* offering shelter and mental health services is most probably due to private agencies taking on this provider role. The high percentages of programs offering substance abuse treatment corresponds with the literature, which indicates that substance abuse can be both a coping mechanism for dealing with the abuse as well as an instigating factor. The low usage of support groups in the PTSD programs raises concern since the literature indicates this as one of the most effective strategies with domestic violence victims' treatment.

Table 6: Treatment Strategies Used by Programs

Treatment Strategy	Domestic Violence Frequency n = 9	PTSD Frequency n = 26
Assessment	n = 9 (100%)	n = 25 (96.1%)
Prevention Services	n = 4 (44.4%)	n = 1 (3.8%)
Outpatient Treatment	n = 9 (100%)	n = 25 (96.1%)
Home-Based Services	n = 0	n = 2 (7.7%)
Day Treatment	n = 0	n = 4 (15.3%)
Emergency Services	n = 6 (66.6%)	n = 21 (80.7%)
Residential-Treatment Services	n = 4 (44.4%)	n = 10 (38.4%)
*Shelter Only	n = 1 (11.1%)	n = 6 (23.1%)
*Mental Health Only	n = 1 (11.1%)	n = 7 (26.9%)
*Both Shelter & Mental Health	n = 2 (22.2%)	n = 4 (15.3%)
Independent Living	n = 2 (22.2%)	n = 7 (26.9%)
Hospitalization	n = 3 (33.3%)	n = 17 (65.3%)
Substance Abuse Treatment	n = 7 (77.7%)	n = 17 (65.3%)
Support Groups	n = 6 (66.6%)	n = 10 (38.4%)
Outreach Services	n = 3 (33.3%)	n = 4 (15.3%)
Case Management	n = 7 (77.7%)	n = 19 (73.1%)

* Subcategories of Residential Treatment

Respondents were then asked to specify what mental health strategies were effective for working with domestic violence victims with PTSD. The qualitative responses were collapsed into Table 7.

Table 7: Effective Strategies for Treating PTSD Symptoms in Domestic Violence Victims (N=26)

<u>SUGGESTED STRATEGY</u>	<u># OF DIRECTORS SUGGESTING THE STRATEGY</u>	<u>PERCENTAGE</u>
Support Groups	13	50
Individual and Group Treatment	10	38.5
Cognitive behavioral treatment strategies	8	30.8
Case Management (advocacy & brokering)	6	23.1
Shelter and housing	5	19.2
Outpatient treatment	4	15.4
Eye Movement Desensitization and Reprocessing	4	15.4
Individual treatment	4	15.4
Education about PTSD	3	11.5
Medication	2	7.6
Crisis intervention/emergency services	2	7.6
In-service training on PTSD and domestic violence	1	3.8
Medical evaluation of victims	1	3.8
Psychiatric evaluation	1	3.8
Substance abuse treatment	1	3.8

Directors thought that group support services or a combination of group services and individual treatment services were effective with PTSD and domestic violence victims. Respondents also frequently suggested cognitive-behavioral treatments. All of these suggestions have empirical support in the previously cited literature.

Model Programs

What are considered model mental health programs for women experiencing domestic violence, PTSD, or both?

Respondents were asked to identify any mental health programs in California offering services to women experiencing domestic violence, PTSD, or both. Six respondents identified seven programs as model programs. The seven programs are:

1. Women Escaping a Violent Environment (WEAVE), Sacramento
2. EYE Counseling and Crisis Center, San Marcos
3. La Casa de Las Madres, San Francisco
4. Family Services of Tulare County
5. Mountain Women's Resource Center, Sonora
6. El Dorado Women's Center, Placerville
7. Rainbow Services, Los Angeles County

Each of the programs was contacted by phone and asked to fax information about its program and the services offered. Only three of the programs supplied information, which is summarized below.

Women Escaping a Violent Environment (WEAVE) is a nonprofit organization specializing in domestic violence and sexual assault prevention and victim assistance. The mission of WEAVE is to reduce victim trauma, promote recovery and decrease the incidence of domestic violence and sexual assault in the community. Established in 1975 by an action group of Hispanic battered women, the WEAVE program now serves as a model and leader for organizations throughout the State of California and the nation. The WEAVE program offers women and children who have been impacted

by domestic violence comprehensive services to meet their needs. WEAVE operates a crisis line, which provides counseling, advocacy and linkage to emergency services. Other services include a legal advocacy program, individual and group counseling for women and children, emergency shelter, and community education and prevention.

EYE Counseling and Crisis Center provides crisis intervention, resources, and referral to North County Inland and Coastal residents through a joint effort with law enforcement and local agencies. Crisis intervention is available both in person by phone. Advocates are also available for court, medical appointment accompaniment for victims of domestic violence, rape, and child abuse.

Educational and therapeutic groups are offered in English and Spanish to women presently living with, or having recently left, a violent or abusive partner. Groups are also available to men who have abused a significant other or are at risk for domestic violence.

In addition, emergency shelter and food is provided to women and children in domestic violence situations who are homeless. Emergency shelter provides counseling, support groups, case management, crisis intervention, problem-solving assistance, group interactions, and follow up.

The Escondido office has support groups and refers clients to San Marcos for counseling services. The San Marcos office has a Domestic Violence Specialist who takes all calls relating to domestic violence. They offer in-home counseling, which is education based and contains information particular to domestic violence. They offer individual, family and group therapy to victims of domestic violence, which includes a domestic violence children's group.

La Casa de Las Madres is a program for battered women and their children that provides comprehensive services to shelter residents designed to offer women long-lasting options toward ending domestic violence and homelessness. La Casa's goal is to "restore dignity, generate hope, evoke courage, and help maximize the potential of [their] clients." Provision of individualized support to shelter residents in addition to outreach and crisis services to women in the community of San Francisco are used to achieve their goal. All services are offered in Spanish and English and are free

of charge. Services include hotline crisis counseling, emergency shelter, community education and outreach, and a Drop-in Counseling Center, which offers individual counseling and support groups to former residents of the shelter and to women who are considering their options. These programs serve to support women and children in the process of moving away from domestic abuse and toward empowerment.

Since each of the seven above programs was identified by respondents' word only, each of the programs was contacted by phone to determine if they had been evaluated for effectiveness. None of the programs had been formally evaluated. This finding suggests a need for scientifically based evaluations by all programs serving domestic violence women. Findings from program evaluations should be disseminated to enable service providers to determine best practice treatment strategies for their clients.

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APPENDIX A

1. Citation
2. Empirical? Yes No
3. If 2, yes, briefly describe research design.
4. Dates of data collection
5. Sample description
6. Variables used in study
7. Research questions/hypotheses
8. Instruments
9. Weaknesses, limitations of design
10. Unique features of the study
11. Findings
12. Implications for practice.
13. Anything interesting in the literature review

APPENDIX B

Studies Addressing Domestic Violence Issues

Study	Sample Description	Instruments	Variables	Findings
Research with Large Probability Samples				
Tjaden & Thoennes (1998)	N=8000 women and 8000 men Comparison to general population as measured by the US Census Bureau's 1995 current population survey Study period November 1995-May 1996	<ul style="list-style-type: none"> ▪ Survey screening questions ▪ Modified version of the Conflict Tactics Scale (CTS) 	<ul style="list-style-type: none"> ▪ Demographics ▪ Physical assault, rape, stalking 	<ul style="list-style-type: none"> ▪ 52% of women and 66% of men were physically assaulted as a child and/or as an adult. ▪ Rape is a crime primarily committed against youth: 22% of raped females were under the age of 12; 32% of raped males were under between 12 and 17 years old. ▪ American Indian/Alaska Native women were most likely to report victimization, while Asian/Pacific Islander women were least likely to report victimization. ▪ 25% of women experienced partner violence compared to 8% men. ▪ 76% of victimized women since age 18 were abused by partners compared to 18% of men. ▪ 32% of women and 16% of men who were raped since age 18 were injured during their most recent rape. ▪ 8% of women and 2 % of men were stalked at some time in their life.
Gelles & Harrop (1989)	3002 female respondents from a national probability sample of 6002 households (=Second National Family	<ul style="list-style-type: none"> ▪ Conflict Tactics Scale (TCS) ▪ Psychiatric Evaluation Research 	<ul style="list-style-type: none"> ▪ Domestic violence, partner abuse ▪ Psychological 	<ul style="list-style-type: none"> ▪ Women who reported experiencing violence and abuse also reported higher levels of moderate and severe psychological distress.

	Violence Survey), lived with their male partner or were separated less than 12 months	<ul style="list-style-type: none"> Interview (PERI) Perceived Stress Scale Marital Conflict Index 2 composite measures of distress (developed by authors) 	distress, marital conflict, women's health	<ul style="list-style-type: none"> Multivariate analysis indicated that violence made an independent and nonspurious contribution to the psychological distress experienced by women.
Quasi-experimental Research Design (2 group design)				
Astin, Ogland-Hand, Coleman & Foy (1995)	<p>N=87 women</p> <ul style="list-style-type: none"> 50 battered women from 5 L.A. area shelters (residents and community clients) 37 nonbattered women from community clinics, therapists, and self-help groups in L.A. area 	<ul style="list-style-type: none"> Structured Clinical Interview for DSM-III-R (SCID-R) Conflicts Tactics Scale-From N (CTS) + added items Screening section on the SCID-R for trauma other than DV 	<ul style="list-style-type: none"> Physical violence/some form of distress by an intimate partner PTSD symptoms Childhood sexual and physical abuse; overall prebattering traumatic experiences 	<ul style="list-style-type: none"> Battered women exhibited significantly higher rates of PTSD than maritally distressed women. Women with a PTSD-positive status were significantly more likely to have experienced self-reported childhood sexual abuse and a higher overall number of previous traumas than those with a PTSD-negative status. Battering exposure and childhood sexual abuse predicted 37% of the variance in overall PTSD intensity levels.
Campbell (1989)	<p>N=193 women</p> <ul style="list-style-type: none"> 97 battered women 96 women having serious problems in an intimate relationship 	<ul style="list-style-type: none"> Tennessee Self-Concept Scale (TSCS) Beck Depression Inventory (BDI) Denyes Self-Care Agency Instrument (DSCAI) SCL-90 Modification Conflict Tactics Scale 	<p>Grief model:</p> <ul style="list-style-type: none"> stressors, powerlessness, perceived loss depression, grief-related physical symptoms <p>Learned helplessness model:</p> <ul style="list-style-type: none"> perceptions of 	<ul style="list-style-type: none"> Both groups scored significantly below normative groups in self-esteem. The battered women had more frequent and severe physical symptoms of stress and grief and had thought of or tried more solutions to the relationship problems.

		<p>(CTS)</p> <ul style="list-style-type: none"> 4-point Likert-scale for blame operationalization 	<p>control in relationship, personal attributions, negative self-evaluation</p> <ul style="list-style-type: none"> depression, difficulty in problem-solving 	
Cascardi & O'Leary (1995)	<p>N=97 women</p> <ul style="list-style-type: none"> 49 abused women, at least 2 acts of physical aggression in the previous year 23 maritally discordant, non-abused women 25 maritally satisfied, non-abused women (community control group) 	<ul style="list-style-type: none"> Structured Clinical Interview for DSM-III-R (SCID) Modified Conflict Tactics Scale (MCTS) Lock-Wallace Short Marital Adjustment Test (SMAT) Psychological Maltreatment of Women Scale (PMTW) Spouse-Specific Fear Measure (SSFM) Child Abuse Assessment (CAA) 	<ul style="list-style-type: none"> Abuse by an intimate partner Childhood physical and sexual abuse Coerciveness of spouses, being fearful of spouses, Psychological symptomatology 	<ul style="list-style-type: none"> Abused women reported significantly more fear of their spouses and reported that their spouses were significantly more coercive and psychologically aggressive. Abused women and maritally discordant women reported higher rates of emotional abuse in childhood than maritally satisfied non-abuse women. Abuse women reported higher rates of PTSD than women in the discordant-only and community control groups.
Dalton & Kantner (1983)	<p>N=52 women</p> <ul style="list-style-type: none"> 26 women who were residing in 2 residential treatment shelters for battered women 19 non-battered women from a community 	<ul style="list-style-type: none"> Quick Test Hand Test 	<ul style="list-style-type: none"> Anger, aggression, acting out Domestic violence 	<ul style="list-style-type: none"> Battered women displayed more acting out and aggression than the non-battered women and showed lessened capacity to manipulate the environment constructively. No group differences in intelligence and age.

	<ul style="list-style-type: none"> college 9 “community-battered” women (former members of non-battered women’s group) 			
Dutton & Painter (1993)	<p>N=75 women; recruited over a 6-month period</p> <ul style="list-style-type: none"> 50 battered women, left the relationship in the past 6 months, 2 or more incidents of severe physical abuse 25 emotionally abused women, less than 2 incidents of physical abuse, no severe physical abuse 	<ul style="list-style-type: none"> Kitson scale Rosenberg Self-Esteem Scale Trauma Symptom Checklist Conflict Tactics Scale (CTS) Psychological Maltreatment of Women Inventory (PMWI) Subjective Intermittency Scale (developed by authors) Marlowe-Crowne Social Desirability Scale 	<ul style="list-style-type: none"> Attachment, self-esteem, trauma symptoms Aggression/violence, maltreatment, intermittency of abuse, power, investment, women’s history, finances 	<ul style="list-style-type: none"> The study found support for the effect of extremity of intermittent maltreatment and power differentials on long-term felt attachment for a former partner, experienced trauma symptoms, and self-esteem, immediately after separation from an abusive partner and again after a six-month period. After 6 months attachment had decreased by about 27%. Total abuse, intermittency of abuse and power differentials accounted for 55% of the variance in the attachment measure at Time 2.
Follette, Polusny, Bechtle & Naugle (1996)	<p>N=210 women</p> <ul style="list-style-type: none"> 72 women with a history of child sexual abuse, adult sexual assault or physical partner abuse 138 women recruited from the undergraduate pool of a university, 	<ul style="list-style-type: none"> Personal Data Survey (PDS) Conflict Tactics Scale (CTS) Trauma Symptom Checklist-40 (TSC-40) 	<ul style="list-style-type: none"> Child sexual abuse, adult sexual assault, physical partner abuse Trauma symptoms 	<ul style="list-style-type: none"> Victimization and revictimization are frequent. The level of trauma specific symptoms is significantly related to the number of different types of reported victimization experiences.

	nonclinical			
Gleason (1993)	<p>N=62 battered women receiving services in Florida</p> <ul style="list-style-type: none"> ▪ 30 battered women living in a shelter ▪ 32 battered women living at home sometimes with or without the batterer <p>Comparison group: 10953 random national sample adjusted to 1980 census</p>	<ul style="list-style-type: none"> ▪ Diagnostic Interview Schedule (DIS) 	<ul style="list-style-type: none"> ▪ Physical partner abuse ▪ Mental disorders 	<ul style="list-style-type: none"> ▪ Extremely high prevalence was found for psychosocial dysfunction, major depression, PTSD, generalized anxiety disorder, and obsessive-compulsive disorder.
Launius & Jensen (1987)	<p>N=57 women female students</p> <ul style="list-style-type: none"> ▪ 19 battered women ▪ 19 battered women who are in counseling ▪ 19 nonbattered women 	<ul style="list-style-type: none"> ▪ Beck Depression Inventory (BDI) ▪ State-Trait Anxiety Inventory-Form Y (STAI-Y) ▪ Revised Beta Examination ▪ 3 general and 3 abusive interpersonal problem situations based on the Interpersonal Problem Solving Assessment Technique (Claerhout) 	<ul style="list-style-type: none"> ▪ Battery experience ▪ Depression, anxiety, problem-solving skills 	<ul style="list-style-type: none"> ▪ No significant difference was found between the groups for intelligence, but the counseling women were significantly more depressed and anxious than the battered and control women. ▪ Battered women (1) generated fewer total options, (2) generated fewer effective options, and (3) chose fewer effective options for use in the situation than both counseling and control women.
Mancoske, Standifer & Cauley	<p>N=20 battered women who requested short-term counseling services at a</p>	<ul style="list-style-type: none"> ▪ Hudson's Index of Self-Esteem (ISE) ▪ Self-Efficacy Scale 	<ul style="list-style-type: none"> ▪ Feminist oriented counseling/grief solution oriented 	<ul style="list-style-type: none"> ▪ Overall, the 20 women reported improved self-esteem, self-efficacy, and more positive attitudes toward feminism.

(1994)	<p>battered women's program</p> <ul style="list-style-type: none"> 10 women assigned to feminist oriented approach 10 women assigned to grief solution oriented approach 	<p>(SES)</p> <ul style="list-style-type: none"> Attitudes Toward Feminism Scale (ATFS) 	<p>counseling</p> <ul style="list-style-type: none"> Self-esteem, self-efficacy, attitudes toward feminism 	<ul style="list-style-type: none"> However, these improvements were found to have occurred primarily among the clients receiving grief-resolution-oriented counseling, not among those receiving feminist counseling.
Nurius, Furrey & Berliner (1992)	<p>N=106 women</p> <ul style="list-style-type: none"> 26 women whose partners are abusive to them 30 women whose partners are sex offenders of children for whom the woman is a parent 23 women whose partners are sex offenders of children for whom the woman is not a parent 27 women whose partners do not engage in abuse 	<ul style="list-style-type: none"> Index of Self-Esteem Mastery Scale Generalized Contentment Scale Family Environment Scale Dyadic Adjustment Scale Index for Victimization History 	<ul style="list-style-type: none"> Quality levels of relationship: abuse by partners towards partners or children linked with vulnerability factors Coping responses (cognitive, emotional, and behavioral reactions to the abuse) and coping resources 	<ul style="list-style-type: none"> There were significant differences in coping capacity profiles across the four groups. These appeared to be a continuum of coping capacity, with women who were most directly threatened showing the lowest and women who were least directly threatened showing the highest levels of coping capacity.
O'Keefe (1998)	<p>N=76 self-identified battered women convicted of various criminal offenses</p> <ul style="list-style-type: none"> 50 incarcerated women for homicide/serious assault of their partners 26 incarcerated women for other offenses 	<ul style="list-style-type: none"> Conflict Tactics Scale-Violence Subscale (CTS) Los Angeles Symptom Checklist (LASC) Childhood Violence Scale (CVS) Likert-scales for 	<ul style="list-style-type: none"> Physical/sexual partner abuse, killing/serious assault of partner PTSD symptomatology, social support, time elapse since living with 	<ul style="list-style-type: none"> Battered women who killed/seriously assaulted their batterers experienced more frequent and severe spousal abuse than those in the comparison group. No significant group differences were found for present PTSD symptom levels. Predictors for present PTSD symptomatology included: childhood sexual abuse, childhood physical abuse,

		<p>childhood trauma variables and perceived social support</p> <ul style="list-style-type: none"> ▪ Questionnaire for demographics 	<p>partner, receiving counseling in prison</p>	<p>past PTSD symptomatology, length of time elapsed since living with partner and receiving counseling in prison.</p>
<p>Riggs, Kilpatrick & Resnick (1992)</p>	<p>N=143 women</p> <ul style="list-style-type: none"> ▪ 47 female victims of completed rape or an aggravated sexual assault (a) Marital rape only group (N=14) (b) Stranger rape only group (N=10) (c) Marital assault only group (N=12) (d) Other assault only group (N=11) ▪ 96 women who had not been the victim of a rape, other sexual assault, aggravated assault, robbery or burglary 	<ul style="list-style-type: none"> ▪ Structured interview ▪ Symptom Checklist-90-R (SCL-90-R) ▪ Impact of Event Scale (IES) 	<ul style="list-style-type: none"> ▪ Marital rape, stranger rape, marital assault, other assault ▪ Symptoms of psychological distress 	<ul style="list-style-type: none"> ▪ Crime victims reported higher levels of psychological distress than did the non-victimized women across a variety of symptom areas. ▪ There were no group differences among the four victim groups on any of the measures. ▪ Women assaulted by their husbands were more likely to report that the assault was one of a series of similar attacks. ▪ Victims of aggravated assault were more likely than rape victims to report that they feared for their lives during the assault.
<p>Roth, Newman, Pelcovitz, Bessel van der Kolk & Mandel (1997)</p>	<p>N=234 treatment seeking individuals (189 women, 45 men); study period 1991-1992</p> <ul style="list-style-type: none"> ▪ N=106: clinical sample, recruited from various psychiatric clinics across 5 sites 	<ul style="list-style-type: none"> ▪ Potential Stressor Events Interview (PSEI) ▪ Structured Clinical Interview for DSM-III-R (SCID-Patient Version) ▪ Diagnostic Interview 	<ul style="list-style-type: none"> ▪ Type of abuse, duration of abuse, onset of abuse ▪ PTSD, Complex PTSD (CP) 	<ul style="list-style-type: none"> ▪ Sexually abused women, especially those who also experienced physical abuse, had a higher risk of developing CP, although CP symptoms occurred at a high base rate among physically abused women.

	<ul style="list-style-type: none"> ▪ N=128: community sample, recruited through random digit dial telephone (a) Sexual abuse only (b) Sexual and physical abuse (c) Physical abuse only 	<ul style="list-style-type: none"> ▪ Schedule (DIS) ▪ Structured Interview for Disorders of Extreme Stress 		
Saunders (1994)	<p>N=192 battered women</p> <ul style="list-style-type: none"> ▪ 159 women who had obtained help at a shelter-based program (DVP) ▪ 33 women who had obtained help elsewhere (NDVP) 	<ul style="list-style-type: none"> ▪ Diagnostic Interview Schedule ▪ Impact of Event Scale ▪ Posttraumatic Stress Scale for Family Violence ▪ Marks Fear Questionnaire ▪ Beck Depression Inventory ▪ Rosenberg Self-Esteem Scale ▪ Characteristics of Partners ▪ Expanded Conflict Tactics Scale of Aggression ▪ Injury Scale 	<ul style="list-style-type: none"> ▪ Domestic violence ▪ PTSD symptoms, depression, self-esteem, social phobia, agoraphobia 	<ul style="list-style-type: none"> ▪ 66% of the women in the DVP group and 62% in the NDVP group met criteria for a diagnosis of PTSD. ▪ The most common symptoms were: nightmares intrusive memories of the abuse, avoiding reminders of it, and hyperarousal, and nightmares. ▪ DVP women experienced a variety of symptoms more frequently. ▪ Group differences in PTSD symptomatology were not present after statistically controlling for severity and frequency of the violence and length of time since the abusive relationship.
Schlee, Heyman & O'Leary (1998)	<p>N=84 married couples seeking treatment for marital conflict (64 couples dropped out, 34 couples completed the</p>	<ul style="list-style-type: none"> ▪ Structured Clinical Interview of the DSM-III-R (SCID) ▪ Modified Conflict Tactics Scale (CTS) 	<ul style="list-style-type: none"> ▪ Mild to moderate spouse abuse ▪ PTSD symptomatology ▪ PACT, GST 	<ul style="list-style-type: none"> ▪ Across all women, avoidance symptomatology significantly differentiated treatment completers from dropouts. ▪ Although women with PTSD began

	<p>program), random assignment to:</p> <ul style="list-style-type: none"> Physical Aggression Couples Treatment (PACT)→7 groups Gender Specific Treatment (GST)→5 groups 	<ul style="list-style-type: none"> Psychological Maltreatment of Women Scale (PM) 2-item fear scale Dyadic Adjustment Scale (DAS) Beck Depression Inventory (BDI) Consumer Satisfaction Scale 		<p>treatment in worse condition, post-assessment revealed they achieved positive treatment gains parallel to those of women without PTSD.</p> <ul style="list-style-type: none"> Women with PTSD improved on each outcome variable measured, including a reduction in fear of spouse. Women with PTSD also did not differentially drop out of either treatment condition.
Scott-Gliba, Mine & Mezey (1995)	<p>N=30 women</p> <ul style="list-style-type: none"> 15 women who had experienced at least one abusive relationship, current or previous residents of shelter Comparison group: recruited from an immunization clinic, matched sample in age and status 	<ul style="list-style-type: none"> Semi-structured interview General Health Questionnaire (GHQ) Irritability, Depression and Anxiety Scale Rosenberg Self-Esteem Scale Impact of Event Scale (IES) 	<ul style="list-style-type: none"> Domestic violence Personal history, physical and mental health, self-esteem 	<ul style="list-style-type: none"> The battered women were found to have lower self-esteem, higher rates of depression, generalized anxiety and fearfulness, increased stress-related symptoms, irritability and suicidal ideation. The level of psychosocial and behavioral disturbance in the women who had been battered was not present in the comparison group.
Thompson, Kaslow, Kingree, Puett, Thompson & Meadows (1999)	<p>N=204 women</p> <ul style="list-style-type: none"> 119 women who presented to the hospital following a nonfatal suicide attempt 85 women who presented to the hospital for nonemergency medical problems with no history of suicidal behavior 	<p>2-hr questionnaire in a face-to-face interview format:</p> <ol style="list-style-type: none"> Rapid Estimate of Adult Literacy Revised version of the Traumatic Stress Schedule Index of Spouse Abuse (ISA) National Women's Study PTSD Module 	<ul style="list-style-type: none"> Partner abuse PTSD symptomatology Suicidal behavior 	<ul style="list-style-type: none"> Physical partner abuse, but not nonphysical partner abuse, was associated with an increased risk for PTSD. PTSD mediated the link between physical partner abuse and suicidality, such that when PTSD was statistically controlled, the association between physical partner abuse and suicide attempt status was reduced to nonsignificance.

Vitanza, Vogel & Marshall (1995)	N=93 women in “bad” or “stressful” relationships, recruited through newspaper ads, public service announcements and flyers <ul style="list-style-type: none"> No violence (N=31) Moderate violence (N=30) Severe violence (N=32) 	<ul style="list-style-type: none"> Severity of Violence Against Women Scales (SVAWS) Private Self-Consciousness Subscale of the Private and Public Self-Consciousness Scale Cognitive Failures Questionnaire Symptom Checklist 90-Revised (SCL-90-R) Crime-related PTSD subscale of SCL-90 Impact of Event Scale 	<ul style="list-style-type: none"> Intrusive thoughts, avoidance, PTSD scores Cognitive failure, private self-consciousness 	<ul style="list-style-type: none"> All groups reported serious emotional distress on the SCL-90-R dimensions. Psychoticism was the highest subscale for all groups. Most women (56%) suffered PTSD according to a subscale of the SCL-90. Difficulties with perception, memory, and motor functions more consistently predicted intrusive thoughts, PTSD scores, and attempted suicide than did women’s attention to their inner thoughts and feelings, which was important for the sample and the subgroup that had sustained severe violence.
Wileman & Wileman (1995)	N=16 female victims of domestic violence <ul style="list-style-type: none"> Group A: partners not attending a men’s group Group B: partners attending a men’s group 	<ul style="list-style-type: none"> Profile of Mood Stats (POMS) Index of Spouse Abuse (ISA) Eysenck Personality Inventory (EPI) 	<ul style="list-style-type: none"> Domestic violence (frequency, intensity) Vulnerability 	<ul style="list-style-type: none"> In both groups violence and vulnerability decreased significantly. Group A had the larger decrease. Fear decreased continuously through all 4 measures. Neuroticism decreased significantly.
Survey – Cross-sectional				
Andrews & Brewin (1990)	70 women who had experienced marital violence from the inner-city area of London	<ul style="list-style-type: none"> Semi-structured interview Present State Examination 	<ul style="list-style-type: none"> Marital violence Childhood abuse; depression; attributions of 	<ul style="list-style-type: none"> Women currently living with violent partners reported the highest rate of self-blame, and women no longer living with such a partner reported a significant

		<ul style="list-style-type: none"> ▪ Life Events and Difficulties Schedule (LEDS) ▪ Straus's Severe Violence Index ▪ 3-, 4- and 7-point scales 	responsibility for violence; social network involvement	<p>change from past self-blame to current partner-blame.</p> <ul style="list-style-type: none"> ▪ Characterological self-blame was shown to be most highly associated with repeated physical or sexual abuse in childhood, lack of social support concerning the violence, and a high rate of depression once out of the relationship.
Astin, Lawrence & Foy (1993)	53 battered women from 3 L.A. area shelters and one counseling center	<ul style="list-style-type: none"> ▪ Impact of Event Scale (IES) ▪ PTSD Symptom Checklist ▪ Conflict Tactics Scale-Form N (CTS) ▪ Social Support Questionnaire (SSQSR) ▪ Life Experience Survey (LES) ▪ Age Universal Religious Orientation Scale ▪ Self-report questionnaire designed by authors 	<ul style="list-style-type: none"> ▪ Physical partner abuse ▪ PTSD symptomatology ▪ Social support; intercurrent life events; religiosity; developmental family stressors 	<ul style="list-style-type: none"> ▪ A significant proportion of battered women was diagnosed as PTSD positive. ▪ Violence exposure severity, recency of the last abusive episode, social support, intercurrent life events, intrinsic religiosity, and developmental family stressors predicted 43% of the variance in PTSD symptomatology.
Bowker & Maurer (1987)	N=1000 battered women who responded to a national magazine solicitation, nonprobability sample Quantitative data from 334 subjects Qualitative data from 146	<ul style="list-style-type: none"> ▪ Questionnaire designed by the authors ▪ Letters with case histories ▪ "supplementary letters" 	<ul style="list-style-type: none"> ▪ Domestic violence ▪ Population characteristics ▪ Women's satisfaction with medical services 	<ul style="list-style-type: none"> ▪ In comparison with other help-sources, medical personnel were found to have been used fairly frequently, but the battered women saw them as less effective, than any other group.

	subjects	<ul style="list-style-type: none"> ▪ In-depth interviews 		
Cascardi & O'Leary (1992)	33 battered women, help-seeking	<ul style="list-style-type: none"> ▪ Modified Conflict Tactics Scale (MCTS) ▪ Injury Index ▪ Blame Scale ▪ Beck Depression Inventory (BDI) ▪ Rosenberg Self-Esteem Scale (RSE) 	<ul style="list-style-type: none"> ▪ Physical abuse (frequency, severity, duration) ▪ Depressive symptomatology, self-esteem, self-blame/partner blame 	<ul style="list-style-type: none"> ▪ As the number, form, and consequences of physically aggressive acts increased and/or worsened, the women's depressive symptoms increased and self-esteem decreased. ▪ Only 12% of the sample blamed themselves for causing their partner's violence. ▪ Neither self-blame nor partner blame was associated with length of abuse or the frequency and severity of physical aggression.
Dutton, Burghardt, Perrin, Chrestman & Halle (1994)	72 battered women, from an urban specialized family violence outpatient clinic	<ul style="list-style-type: none"> ▪ Traumatic Stress Institute Belief Scale-Version D (TSI) ▪ Attribution to Violence (ATB) and Appraisal of Violence (APV) Questionnaire ▪ Global Symptom Index (GSI) ▪ CR-PTSD Scale (derived from SCL-90-R) ▪ MMPI-derived PTSD subscale ▪ Intrusion and Avoidance subscales from the Impact of Event Scale (IES) 	<ul style="list-style-type: none"> ▪ Physical abuse, cognitive schemata ▪ Psychological distress, PTSD, childhood sexual abuse 	<ul style="list-style-type: none"> ▪ The meaning of the violence was found to explain variance in cognitive schemata about safety, self, and other. ▪ All measures of cognitive schemata were significantly related to various global and specific measures of posttraumatic stress. ▪ No differences were found for cognitive schemata based on histories of sexual victimization.
Finn (1985)	56 women seeking help	<ul style="list-style-type: none"> ▪ Demographic 	<ul style="list-style-type: none"> ▪ Physical spouse 	<ul style="list-style-type: none"> ▪ Battered women experience stress from

	from a spouse-abuse treatment program	<ul style="list-style-type: none"> information sheet Stress scale (with 10 stressors) F-Copes Scale 	<ul style="list-style-type: none"> abuse Problem-solving skills, stressors 	<ul style="list-style-type: none"> multiple sources but are deficient in coping skills. Both men and women involved in marital violence fail to use problem-solving strategies.
Follingstad, Brennan, Hause, Polek & Rutledge (1991)	234 women with some history of abuse, volunteers	<ul style="list-style-type: none"> Questionnaire (designed by the authors), over the phone interview format, 2-3 hrs. 	<ul style="list-style-type: none"> Moderating variables of physical and emotional abuse (frequency, severity, predictability, controllability, social support) Psychological and physiological symptoms 	<ul style="list-style-type: none"> Frequency is a strong predictor of the number and severity of symptoms. Those women who could predict abuse experienced more symptoms. A model including women with more injuries requiring medical attention predicted severity of physical and psychological symptoms, women adhering to traditional sex role values, and the presence of one type of emotional abuse. Battered women perceived their physical and emotional health as deteriorating during the relationship and during the abuse, but as getting healthier after the abuse ended.
Hattendorf, Ottens & Lomax (1999)	18 battered women who had killed their male abusive partners Study period Spring 1996	<ul style="list-style-type: none"> Clinician-Administered PTSD Scale-Form 1 (CAPS-1) Modified PTSD Symptom Scale-Self Report (MPSS-SR) Severity of Violence Against Women Scales (SVAWS) 	<ul style="list-style-type: none"> Physical partner abuse PTSD symptomatology 	<ul style="list-style-type: none"> Before killing male partners, battered women suffered moderate to high levels of PTSD symptom frequency and severity, except for an inability to recall important aspects of the trauma. Significant cononical correlations between the frequency and severity of PTSD symptoms and the severity of types of abuses inflicted.
Houskamp &	26 women who had been in	<ul style="list-style-type: none"> Conflict Tactics Scale 	<ul style="list-style-type: none"> Physical partner 	<ul style="list-style-type: none"> Results indicated that 45% of those

Foy (1991)	a physically violent relationship, recruited through 2 L.A. area domestic violence clinics; 6-month study period	<p>(CTS-R)</p> <ul style="list-style-type: none"> ▪ Structured Clinical Interview (SCID) ▪ Symptom Checklist ▪ Impact of Event Scale (IES) 	<p>violence</p> <ul style="list-style-type: none"> ▪ PTSD symptomatology 	<p>subjects interviewed met full DSM-III-R criteria for PTSD on the SCID, and that exposure to violence was significantly associated with PTSD symptomatology.</p> <ul style="list-style-type: none"> ▪ When divided into high and low exposure groups based on degree of life threat, 60 % of those in the high exposure group met criteria for diagnosable PTSD in contrast to a 14% rate in the lower exposure group.
Kemp, Rawlings & Green (1991)	77 battered women from shelters in a mid-western city	<ul style="list-style-type: none"> ▪ Impact of Event Scale (IES) ▪ Symptom Checklist 90-R (SCL 90-R) ▪ Interview Schedule for PTSD ▪ Demographic Questionnaire Inventory 	<ul style="list-style-type: none"> ▪ Battery experiences (extent, length, distress) ▪ PTSD symptomatology 	<ul style="list-style-type: none"> ▪ 84% of the sample met the DSM-III-R criteria for PTSD according to self-report. ▪ The reported subjective distress regarding the battery experience was positively correlated with presence and degree of PTSD, intrusion, depression, anxiety, and general psychopathology. ▪ Extent of abuse was positively related to presence and degree of PTSD, depression, anxiety, and overall symptom distress. ▪ Length of the abusive relationship was least related to the outcome variables.
Khan, Welch & Zillmer (1993)	31 battered women (residents in a shelter); 18-month study period	<ul style="list-style-type: none"> ▪ MMPI-2 ▪ Questionnaire on the length and types of abuses (developed by the authors) 	<ul style="list-style-type: none"> ▪ Length and type of domestic violence ▪ Psychological disturbances 	<ul style="list-style-type: none"> ▪ Significant relationships between length and severity of psychological forms of abuse and overall levels of psychological distress ▪ Length of abuse is the best single predictor for psychological distress. ▪ Severity of psychological abuse is the only predictor of the overall average score.

				<ul style="list-style-type: none"> Age and physical severity of abuse did not show significant results.
Perrin, Hasselt, Basilio & Hersen (1996)	69 battered women who were clinically referred to an outpatient clinic, assigned to PTSD-positive or PTSD-negative groups	<ul style="list-style-type: none"> Minnesota Multiphasic Personality Inventory (MMPI)-Keane PTSD Scale (PK) Symptom Checklist-90-Revised (SCL-90-R) Impact of Event Scale (IES) Veronen-Kilpatrick Modified Fear Survey Interpersonal Support Evaluation List (ISEL) Structured Clinical Interview for DV (SCIDV) 	<ul style="list-style-type: none"> PTSD status PTSD symptomatology, trauma-related fears, psychological distress, history of abuse 	<ul style="list-style-type: none"> The PTSD-positive group scored significantly higher across all measures of PTSD and distress. The 2 groups differed only for the frequency of death threats. Lower levels of perceived social support were found in the PTSD-positive than the PTSD-negative group.
Rollstin & Kern (1998)	50 women with a history of physical or emotional abuse in a domestic relationship	<ul style="list-style-type: none"> MMPI-2 Conflict Tactics Scale (CTS) 	<ul style="list-style-type: none"> Physical and emotional abuse (frequency, severity, duration, time of determination) Psychological distress 	<ul style="list-style-type: none"> MMPI-2 scores were significantly correlated with both types of abuse but not with duration of time since the abusive relationship was terminated.
Rosen (1999)	35 teenage mothers at high risk for partner abuse, recruited through adolescent health clinic	<ul style="list-style-type: none"> Life History Interview Conflict Tactics Scale (CTS) 	<ul style="list-style-type: none"> Teenage status and pregnancy Partner abuse 	<ul style="list-style-type: none"> 64% had experienced partner violence in their lifetime 40% were diagnosed with severe depression, 33% with dysthymia, and

		<ul style="list-style-type: none"> ▪ Psychological Maltreatment of Women Inventory (PMWI) ▪ Composite International Diagnostic Interview-Short Form plus PTSD Module (CIDI-WHO) 		<p>over 59% with PTSD.</p> <ul style="list-style-type: none"> ▪ 63% of total sample had one of these mental disorders in their lifetime.
Varvaro (1991)	23 battered women, recruited through a shelter-based resident support group and a community support group	<ul style="list-style-type: none"> ▪ Grief Response Assessment Questionnaire (developed by the author) 	<ul style="list-style-type: none"> ▪ Stages of grief ▪ Need for support groups 	<ul style="list-style-type: none"> ▪ Women in different stages have different needs: <ul style="list-style-type: none"> (a) In attachment stage: need for safety, security, community living, housing, food, clothing, financial & legal resources (b) In attachment/detachment stage: need for socialization, discovery of hopes, dreams, and feelings (c) In detachment stage: need for achievement of goals, problem solving, and decision making skills
West, Fernandez, Hillard, Schoof & Parks (1990)	30 physically abused women from a protective shelter in Ohio; study period February-October 1989	<ul style="list-style-type: none"> ▪ Inventory to Diagnose Depression (IDD) ▪ Hamilton Psychiatric Rating Scale for Depression ▪ Structured Clinical Interview for DSM-III-R-PTSD Module (SCID) ▪ Modified Conflict Tactics Scale (CTS) 	<ul style="list-style-type: none"> ▪ Psychiatric disorders 	<ul style="list-style-type: none"> ▪ High prevalence of major depression disorder (37%) and PTSD (47%) were determined. ▪ These disorders were found to be positively associated.

Survey – Longitudinal/Retrospective				
Bergman & Brismar (1991)	117 battered women seeking help in an emergency room in Swede 117 women selected from the population register Study period November 1983 to June 1984 Data collection from period of 10 years before and 5 years after the battering	<ul style="list-style-type: none"> ▪ Data from County Council's computer files and from medical records 	<ul style="list-style-type: none"> ▪ Battering ▪ Somatic hospital care; psychiatric care; sociodemographic data 	<ul style="list-style-type: none"> ▪ During the 5 years following the battering, the women did not show any signs of reducing their use of hospital care.
Roberts, Lawrence, Williams & Raphael (1998)	N=335 women recruited from the Royal Brisbane Hospital Emergency Department (Australia) through the Primary Care Section (N=238), the Acute Overnight Stay Section (N=84), acute referrals in the Emergency Department (N=6), and referrals from community agencies (N=7) Study period September 1995 to June 1996	<ul style="list-style-type: none"> ▪ Screening questionnaire ▪ Composite Abuse Scale (CAS) ▪ Composite International Diagnostic Interview (CIDI-WHO) ▪ PTSD-Checklist (PCL-S) ▪ Alcohol Use Disorders Identification Test (AUDIT) 	<ul style="list-style-type: none"> ▪ Child abuse only, adult abuse only, child & adult abuse, no abuse 	<ul style="list-style-type: none"> ▪ Women who reported lifetime adult intimate abuse received significantly more diagnoses of generalized anxiety, dysthymia, depression, phobias, current harmful alcohol consumption and psychoactive drug dependence than those who reported no abuse ever. ▪ Of women tested for lifetime PTSD, those who reported lifetime abuse received significantly more diagnoses than those who reported no abuse. ▪ Crude prevalence rates of psychiatric diagnoses for women who reported double abuse as child and adult were significantly higher than for women who reported adult intimate abuse only. ▪ Adjusted rates showed that doubly abused women had significantly greater risk of current harmful alcohol consumption and lifetime drug dependence than women

				<p>who reported adult abuse only.</p> <ul style="list-style-type: none">▪ A significant independent factor for lifetime psychiatric diagnoses was reporting abuse between a woman's parents.▪ Measurement of the population attributable risk found that one-third of the psychiatric diagnoses was attributable to domestic violence.
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APPENDIX C

Women, Domestic Violence, and Mental Health Treatment Questionnaire

County Mental Health Agency _____

Person completing questionnaire _____

Title of person completing questionnaire _____

Date completed _____

1. Does your agency/department, or any other public agency in your county, have a program(s) designed specifically to provide mental health services to women who have experienced domestic violence?

- Yes
- No **____SKIP TO #5.**

2. Approximately how many women are served a year by this program? _____

Approximately what percentage are the following cultural or ethnic groups:

Check this box if you do not keep records of culture or ethnicity.

White (nonHispanic) _____

Hispanic _____

African Decent _____

Asian _____

Pacific Islander _____

Native American _____

3. Check the mental health treatment strategies listed below that you currently use with domestic violence clients.

Assessment

What specific symptoms do you assess for? (E.g., depression) _____

-
- Prevention services
 - Outpatient treatment
 - Home-based services
 - Day treatment
 - Emergency services

- Residential-treatment services
 - Shelter only
 - Mental health only
 - Both shelter & mental health

- Independent living
- Hospitalization
- Substance abuse
- Support groups
- Outreach services
- Case management
- Other strategies not mentioned that you use_____

If none of the above services are offered, skip to #5.

4. Are any of the services circled in #3 tailored to meet the needs of specific cultural or ethnic groups?

- Yes
Specify which groups_____
- No

5. Do you provide mental health services to women who have experienced Post-Traumatic Stress Disorder (PTSD), whether or not they are also experiencing domestic violence?

- Yes
- No___**SKIP TO #7.**

6. Check the mental health treatment strategies listed below that you currently use with PTSD clients.

- Assessment for PTSD
- Prevention services for PTSD
- Outpatient treatment
- Home-based services
- Day treatment
- Emergency services
- Residential treatment services
 - Shelter only
 - Mental health only
 - Both shelter & mental health
- Independent living
- Hospitalization
- Substance abuse
- Support groups
- Outreach services
- Case management
- Other strategies not mentioned that you use_____

7. In your opinion what do you think are the most effective mental health strategies for treating clients experiencing domestic violence?

8. In your opinion what do you think are the most effective mental health strategies for treating clients with PTSD, whether or not domestic violence is present?

9. Do you consider any programs in California that provide mental health services for women experiencing domestic violence, PTSD or both to be model programs?

- Yes___ **Identify them and give a brief description of why you consider them model programs.**

Name_____

Address_____

Phone number_____

Description_____

If there is more than one, use the back of the questionnaire. Thank you for your time. Please return the questionnaire in the enclosed envelope or fax it to Dr. Margaret Hughes at 619-594-5991.

- No

