He drove me mad.
An investigation into the relationship between domestic violence and mental illness.

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Abstract.

This thesis investigated the relationship between the domestic violence that women have experienced, their subsequent feelings of being 'crazy', and the role of mental health services. The investigation identified a gap where services for women who suffer abuse from their male partners intersect with services for people who have mental illness.

The research involved a literature review, interviews with thirty people and analysis of the data gathered from these sources. Ten women with personal experience of domestic violence from their partners and twenty service providers were interviewed. The data were analysed from a feminist perspective. Themes were identified and were analysed in accordance with phenomenological processes.

The interviews with ten women who had experienced domestic violence as adults were conducted to elicit their understanding of the relationship between the abuse they experienced and their subsequent mental illness or feelings of ‘going crazy' and to explore what they thought would have been a useful professional response to their situation.

The twenty key informant interviews were with a case worker at a domestic violence service; a health promoter specialising in domestic violence; two mental health social workers; an occupational therapist with a mental health team; four psychologists; a volunteer at a domestic violence service; two community mental health workers; a counselor with a helping agency who specialises in working with men; a public health nurse; district court staff, a police domestic violence coordinator and a refuge social worker. All of these people had work that brought them into contact with abused women. The interviews were designed to elicit professional understandings about the relationship between the abuse a woman had suffered in a domestic adult relationship and a subsequent diagnosis of mental illness and to explore what the participants thought needed to happen to enable mental health services to respond to any apparent relationship between domestic violence and mental illness.

The major finding was that domestic violence drives women 'crazy' and that the response of existing services was ineffective. One of the major themes to emerge from this research was that women, whose perceptions are constantly challenged, lose their sense of groundedness and reality, and find it increasingly difficult to trust their own perceptions of events. Such women, with or without the extra trauma of physical and sexual abuse, exhibit some behaviours that can be read as symptoms of mental illness. These behaviours are, however, responses to living in intolerable situations. Women in these circumstances require safety and constructive support in order to recover. A diagnosis of mental illness and the implicit denial of their experiences of abuse was inappropriate and damaging for these women. The consequences of the diagnosis was re-abuse from the institutions that they accessed for help, inappropriate medication, the difficulties caused by the stigma associated with mental illness, continuing trauma, and reinforcement of the behaviour of the abuser.

Abused women and key informants agreed on a number of strategies that would help women who feel that domestic violence has driven them mad. These were: training of professionals (including mental health professionals) in the dynamics and identification of domestic violence; specific refuge services that employ staff trained to work with women suffering from abuse and mental distress; ongoing screening by mental health services for domestic violence and a national campaign to raise public awareness of domestic violence, the mental health effects of abuse, and how to respond to it.

Participants agreed that more understanding of, and discussion among, mental health professionals about the dynamics and consequences of abuse was needed to encourage them to respond in more constructive and proactive ways when domestic violence was encountered.

Public health professionals can also participate in change, by helping to shift the focus of public and organisational thinking about domestic violence from an individual pathology focus to a more holistic perspective, through the use of health promotion strategies. This

would involve them in activities such as the training of mental health and other services and a public awareness campaign.

Information from the literature and this study supported the inference that there is a group of women who are not only abused by their partners, but are also experiencing severe mental distress. Most of these women are not identified by the health services they access. There are a range of services for women who have been abused and for women who experience mental illness. However, at the intersection of these two issues, there appears to be a gap in understanding and effective responses to women. This research begins to fill that gap.

Acknowledgements.

My deep respect and admiration is extended to the women who have lived with domestic violence, for having the courage to share their experiences. I am amazed by their generosity - all of them trust that telling their stories to me will benefit other women. Without these women's commitment to a process of change these stories, and the learning that is gained from them, would continue to be hidden.

This research has also been made possible by the support and encouragement of all the other women who have talked to me about this issue over the past few years, and the key informants that I contacted for the study. All of these people have been generous and open in sharing their experiences and knowledge. While conducting this research has taken two years, it has had a much longer gestation process.

I have appreciated the encouragement, wisdom and commitment of Dr Jennifer Hand who has worked with me as a thesis supervisor. Thank you for your guidance, insight and perseverance with me.

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Contents.

Introduction

> *Violence against women is present in every country, cutting across boundaries of culture, class, education, income, ethnicity and age. Even though most societies proscribe violence against women the reality is that violations against women's human rights are often sanctioned under the garb of cultural practices and norms, or through misinterpretations of religious tenets. Moreover, when the violation takes place within the home, as is often the case, the abuse is effectively condoned by the tacit silence and the passivity displayed by the state and the law-enforcing machinery.* (UNICEF 2000)

This thesis investigates the relationship between the domestic violence a woman has experienced and her subsequent feelings of being 'crazy' and/or receiving a diagnosis of mental illness. It also discusses the responses of mental health services to these women and makes recommendations about how they could respond.

My interest in this subject has developed over a number of years, during which I have worked with women as a health promoter/public health practitioner and listened to their stories. Many women have discussed how they felt that the abuse they had experienced from an intimate male partner had "driven them mad". I wanted to explore this statement. I have also worked, for a number of months, with an Auckland domestic violence service, which included visiting women in their homes after a police call out for domestic violence, supporting women, giving information over the phone and referring women to refuge when appropriate. I was concerned during this time about the discriminatory responses to women who were believed to have psychiatric problems, including being told not to bother with them because they were 'mad', and not being able to access services such as refuge for the same reason. I realised that a very vulnerable group of women were missing out on help, support, compassion and services because of the stereotypical assumptions about them that had been made - which resulted in them being denied services and help.

There is a fairly comprehensive range of services for women who suffer abuse from their intimate partner and for people who have mental illness. However, at the intersection of these two issues, there appears to be a gap in understanding and effective responses to women.

This research is one stage in addressing that gap.

This research is exploratory and involves the participation and collaboration of the many women I have talked to informally over the past few years about this issue and the difficulties involved in addressing it. These conversations have helped me clarify the content and methodology of this research and will ensure that the information gained in the research will be used to educate, inform and lobby for change.

This research is not investigating women's experience of childhood sexual, emotional and/or physical abuse. It is about their experiences of abuse as adults. Also, this research is not discussing what happens when an existing mental illness is complicated by domestic violence.

Language

The language used in this thesis to describe the abusive behaviour of a man towards his female partner will be either domestic violence or abuse. These concepts are explored and described in chapter one.

The relationship between mental illness and domestic violence as a public health issue

This issue may seem, on first appearances, to be a personal health issue rather than one that should be addressed using a public health/health promotion approach. It is, however, an important emerging public health issue for the following reasons.

First of all, this is an issue that affects a sizeable population of women and their families and friends. If women are 'driven crazy' by abuse, it is not only the women themselves who suffer the effects and the consequences, it encompasses everyone involved with them, especially their children. These women cross cultures and socioeconomic groupings, and are, apart from the costs to themselves, costing the country millions of dollars in inappropriate care, lost opportunities and sometimes, lost life. Approaching the problem as an individual treatment issue denies the far reaching effects of domestic violence and the societal structures that work to keep abuse, and abused women, invisible and/or blamed for their abuse.

In order to address this problem constructively a multi- pronged approach must be used. This would include elements from all of the strands identified for health promotion in the Ottawa Charter. (World Health Organisation 1986) This involves Policy Development, Reorienting Health Services, Developing Individual Skills, Developing Supportive Environments and Strengthening Communities.

Chapter Outlines

Chapter One outlines how domestic violence is explained in the literature and what definition of domestic violence is used in this thesis. The chapter then explains the cycle of violence, the incidence of domestic violence in New Zealand and worldwide and the physical effects of living in an abusive relationship. There is an overview of the effects of domestic violence on children, then socioeconomic and cultural issues are considered.

Chapter Two examines some of the theories that have been developed to explain why women enter, and stay in, abusive relationships. Many of these theories have focused on the behaviours and pathologies of the women being abused, without consideration of the structural, cultural and psychological effects of living in an abusive situation. There is also list of practical reasons why women may choose not to leave an abusive situation. Following this there is a short discussion about the process, for women, of leaving and why asking the question "why doesn't she leave?" is not conducive to a discussion about domestic violence.

Chapter Three. This chapter lists two common usage definitions of mental illness and discusses mental illness from three perspectives. There is a brief examination of mental illness from a gender analysis perspective - including a post modern viewpoint, an overview of mental illness from a Maori perspective and a discussion about the DSM IV - the diagnostic tool most often used for the assessment of people who present to New Zealand mental health services.

Chapter Four this chapter first examines the prevalence of a history of physical and/or sexual abuse among people who experience mental illness. It then lists the most usual psychiatric effects of domestic violence, discusses how these may not be symptoms of mental illness and then looks at how a diagnosis can have a negative and stigmatising effect on a woman who is labeled as mentally ill.

Chapter Five examines the Mental Health services response to women who either present with symptoms of abuse or who disclose domestic violence. It examines women's perceptions of Mental Health service staff and Mental Health service staff's knowledge about, and response to, disclosure of domestic violence. It also looks at the relationship between enquiries about domestic violence and childhood sexual abuse. The chapter goes on to discuss issues relating to responding to women who have been abused and who are in contact with mental health/drug and alcohol services. Finally the chapter addresses issues related to the training of mental health professionals and finishes with an examination of the Mental Health service policies related to domestic violence.

Chapter Six this chapter gives an overview of issues surrounding the disclosure of domestic violence to physical health services/practitioners and also outlines four initiatives that have occurred in New Zealand in response to the need for a proactive system to identify and respond to domestic violence.

Chapter Seven discusses the theoretical basis of the methodology used in this study and also provides specific information about the recruiting and interviewing of participants in the research.

Chapter Eight presents the results of the interviews undertaken with health and other professionals who work with abused women, with woman who have been in abusive relationships who also have a history of childhood abuse, and with women who have only experienced domestic violence as adults. The themes from the research material are also presented.

Chapter Nine. This chapter explores the ideas that have been identified in the themes, and looks at what the women who were interviewed during the research want and need in response to their situation. Next there is discussion about the response of mental health services. This is followed by discussion about the role, in domestic violence, of the public health/health promotion sector. Recommendations conclude the chapter.

Domestic Violence

Introduction

This chapter outlines how domestic violence is explained in the literature and what definition of domestic violence is used in this thesis. The chapter then explains the cycle of violence, the incidence of domestic violence in New Zealand and worldwide and the physical effects of living in an abusive relationship. There is an overview of the effects of domestic violence on children, then socioeconomic and cultural issues are considered.

Domestic violence definitions

The purpose of abuse is to destroy a person's will so as to render them pliant and acquiescent. The (NZ) Man Alive Class Manual (1995) describes that process.

> *Male role control works by coercion. Men violate their partners to coerce them into control. Male role control works by physically, verbally or emotionally destroying your partner's physical, intellectual and emotional integrity so that she will be afraid to be herself, will control herself, and therefore be available to be controlled by you.* (Man Alive 1995) page 41

Domestic violence takes many forms and is multi faceted. It is known in the literature as: family violence, spousal abuse, abusive relationships, wife beating and battering of women and children. Besides physical abuse there is psychological, emotional or spiritual violence against women, children and, occasionally, men. It is carried out in a domestic or family setting by an intimate partner who may or may not be living with the abused person. Psychological abuse is insidious as it is usually committed in private and leaves no visible scars. Men are estimated to be responsible for around 95% of domestic violence. (UNICEF 2000)

The present study focuses on violence that is committed against women, by men with whom the women have a sexual/domestic/intimate relationship and is based on the concept that men's power and control issues underlie the expression and direction of violence towards women and children. (Koss, Goodman et al. 1994) This involves the use of force or misuse of power over a person to control and

punish them. (Bames, Fleming et al. 1993) The usual pattern that is identified involves a combination of 'tactics' designed to exert power and control over one person, by another person.

Violence against women is rape, wife-beating, incest, torture, assault, sexual harassment and many kinds of mental and emotional abuse, occurring either within or outside the confines of the home. Church (1984) defines a violent relationship as one in which one partner has become frightened of the other. (Church 1984) This pattern of behavior involves a range of actions that are usually, but not always, reinforced by physical and sexual violence. It includes all or some of the following behaviours that are listed below. (Koss, Goodman et al. 1994) (McBride 1995) (FVPCC 1993) (Church 1984)

Physical abuse

Physical abuse is slapping, punching, shoving, hitting, kicking, biting, beating, using weapons or using objects as weapons, cutting/slashing with knives, scalding with boiling water, choking, torture and poisoning.

Emotional abuse

Emotional abuse is putting someone down or making them feel bad about themselves, calling them names, telling them they are ugly, making them feel stupid, publicly humiliating someone, making them think that they are 'mad or crazy', constantly telling someone they're wrong, untruthful or stupid. For many women, the emotional and psychological abuse they experience is at least as debilitating as the physical abuse. (Heise, Pitanguy et al. 1994)

Unreasonable demands

Unreasonable demands include being forced to do unnecessary housework, forced to cook meals at unreasonable times, prevented from going out, for example by disabling the car, being kept awake for most of the night, not being allowed to disagree or express an opinion, having to wait on, bathe and dress their partners, having to do all of the, for example, housework, farm work or childcare.

Financial control

Financial control involves not having any money of one’s own including for personal necessities such as tampons, denial of food and basic needs, having to beg for money to feed the family, having no say on how money is spent, having to earn all the money in the household, having to budget with

inadequate housekeeping money - and being punished for failing, controlling women's access to health care.

Monitoring and determining a person's activities and associations

Monitoring and determining a person's activities and associations includes controlling the finances, controlling what a person can buy, stalking them, having a third party report on their activities. This also includes isolating a person - controlling what someone does, who they see and talk to, where they go, preventing a person having contact with their family, friends or support systems. This can result in imprisoning someone - making it impossible for them to leave the house.

Sexual abuse

Sexual abuse is rape, including marital rape, that means forced oral, anal or vaginal penetration with a penis or other object, making someone do sexual acts when they don't want to - or that they object to doing, bondage, touching someone sexually, incest, sexual harassment and forced sex with others. It often involves severe violence including biting, choking, pinching, smothering and head banging. Among abused women in the USA the prevalence of coercive intercourse is at least 40%. In Bolivia and Pueto Rico it is reported as 58% and in Columbia it is 46%. (Heise, Pitanguy et al. 1994) Sexual violence can also be the refusal of a man to use a condom, and hence risking the passing on of HIV, STDs and unwanted pregnancy. Sexual violence is associated with some of the most severe outcomes for women victims including serious injury and death. (Ward, Wilson et al. 1995)

Using male privilege

Using male privilege allows a man to treat someone like a servant and make all the decisions. Many societies define women as inferior, and the right to dominate them is considered to be an essential element of being male. (Heise, Pitanguy et al. 1994) American studies suggest that sex role expectations and social/cultural attitudes that accept violence as a way to assert power and control are major contributing factors to domestic violence. They suggest that it is in rigidly controlled traditional families that female children and women are at the greatest risk of violence. This is particularly so in fundamentalist religious families. (Russo 1985)

Cheryl Bernard, the director of the Ludwig Boltzmann Institute of Politics in Austria, states that:

> *Violence against women in the family takes place because the perpetrators feel, and their environment encourages them to feel, that this is an acceptable exercise of male prerogative, a legitimate and appropriate way to relieve their own tension in conditions of stress, to sanction female behavior... or just to enjoy a feeling of supremacy.* Cited in (Heise, Pitanguy et al. 1994) page 29

Mary Koss makes this point even more explicitly.

> *Expectations of male entitlement reflect a combination of male internalisation of the cultural norms of the rights and privileges of both the masculine gender role, which says that men should be strong and dominant over women, and the husband role, which grants men control over their wives.*
> (Koss, Goodman et al. 1994) page 31

Intimidation

Intimidation is causing someone to be fearful by using looks, actions, gestures, or a loud voice, smashing things, destroying property, hurting or killing pets or other people and driving dangerously to frighten someone.

Threats

Threats means making verbal or written threats and/or carrying out threats to do something, for example, hurt someone emotionally or physically, take the children away, hurt or kill children or other people, commit suicide, report someone to welfare or kill someone.

Using children as an abuse strategy

This means using children to make a person feel guilty, to reinforce the abusive behaviours, to give messages or to gain access to an abused partner who has left the relationship. Threats to hurt, kidnap or gain custody of children are also frequently used.

Verbal abuse

Verbal abuse is hurting someone by the way you talk about them or to them, put downs, public abuse, ridicule and an abusive or critical tone of voice.

Blaming, minimising and denying

This means that abusers do not take responsibility for their own behaviour, but instead blame it on the victim, her children, her family, alcohol or some other outside factor. Mostly an abuser's behaviour is blamed on something the victim of his violence has done or not done. Abusers will frequently deny the seriousness of their abuse and may even deny what they have done.

The cycle of violence

Violence of male partners has been conceptualised as a process that is cyclical. The cycle of male behaviour is designed to develop compliance, confusion and an inability to leave the relationship. This cycle comprises the tension building stage, the acute battering incident and then the cessation of violence with, in some relationships, contrition and promises never to be violent again. (Campbell 1984) Walker (1984) cited in (Koss, Goodman et al. 1994) (McBride 1995)

In some relationships this cycle occurs over a period of years or months, for others it happens in weeks, days or hours. For many women, the contrition stage is pivotal in their deciding to remain in the relationship. Each time a man apologises and says that he will never repeat the abusive behaviour again, the woman wants to believe him and stays in the hope that this time he will change. More commonly, however, three things occur. One is that the periods between the acute battering incidents lessen, secondly the contrition stage becomes shorter, less contrite and frequently disappears completely; thirdly, the violence and dangerousness of the abuse increases. (Heise, Pitanguy et al. 1994) (Church 1984)

This abusive cycle - and domestic violence generally - has been compared to the strategies used by the Chinese to 'brainwash' American prisoners of war. (POW's). Similarities found include psychological abuse within a context of violence and the development of emotional dependency based on intermittent reinforcement and the isolation of the victim from their support systems, which results in a validation of the assailant’s beliefs and behaviour. (Romero 1985)

The process used by the Chinese captors was described as the three D's of conversion under coercion: debilitation, dread and dependency. Debilitation included various physical and mental tactics to weaken a person's body and mind including interrogation, isolation, sleep deprivation and forcing a

person to do senseless and painful things. Dread was accomplished through humiliation and degradation or threats of torture or death. Dependency was established by ensuring that the POW knew that he was entirely dependent on the captors for even the basic necessities of life and the process includes brief displays of kindness and friendliness including apologetic gestures. There were also strategies of reward and punishment. All of these processes included repetition and escalated in intensity over time. (Romero 1985) This process has also been recorded by Amnesty International. They list the process of coercion as isolation, monopolisation of perception, induced debility and exhaustion, threats, occasional indulgences, demonstrating omnipotence, degradation and enforcing trivial demands. (Biderman 1998)

These are very similar strategies to those that are utilised by abusive men towards their partners. Romero makes the point that researchers have focused on the cause and effect relationship between captors and POW's, and the psychological profiles of abusive men and their partners. In other words, researchers have looked for the strategies and the effectiveness of the strategies used for brain washing male captives, and have asked why women choose to stay in abusive relationships - ignoring the behaviours of the abusive partner. This is an indication of how the gender of the participants affects the way we understand and study issues. (Romero 1985)

Dutton (1992) identifies the differences between domestic violence and other forms of trauma. These are:

• that when an abused woman first seeks help from a mental health professional or a refuge, she is currently being abused, or is threatened with abuse.
• an abused woman nearly always has multiple experiences of abuse
• that in a domestic violence situation a woman is being abused by someone with whom she has chosen to be involved.
• that she may have a history of exposure to traumatic events that span her entire life**.**

(Dutton 1992)

The prevalence of domestic violence world wide

The World Bank conducted an international literature review of the health costs of violence against women and found prevalence rates of between 20% - 60% for male partner violence among the different countries and cultures of the world. (Heise, Pitanguy et al. 1994) The same figures have been

cited in the latest UNICEF report. (UNICEF 2000) Because it is more easily discussed and quantified, these figures represent primarily physical abuse.

The UNICEF report also identifies that 10%-15% of women report being forced to have sex with their intimate partner. As this is not a crime in many countries – and because in many countries men are assumed to have unlimited sexual access to their wives after marriage, many women do not report unwanted, forced or abusive sex.

Psychological violence is difficult to capture in quantitative studies so it is not possible to gain a picture of the extent of this form of abuse. Many women report that ongoing psychological violence - emotional torture and living with terror - is often more unbearable than physical brutality. (UNICEF 2000)

The American Medical Association report that between 2,000,000 - 4,000,000 women (in America) are battered each year, that there is a 20%-30% lifetime risk for a women to be battered, that 1,500 women are murdered each year by a current or past intimate partner and that 20%-30% of women seen in medical settings may be abuse victims. (American Medical Association 1996)

Homicide

There is a strong relationship between domestic violence and the murder of women by their male partners. This has been renamed 'femicide' by the United Nations. (UNICEF 2000) Nearly two thirds of homicides in New Zealand involve family relationships and nearly two thirds of those killed are women. (Fanslow, Coggan et al. 1995) In 1999 the police believed that 50% of all murders in New Zealand were men killing their partners. (Ward 2000) This equates to 90% of partner homicides being men murdering their partners or ex partners. (Fanslow 2001)

Data from a wide range of countries support this connection. In Canada 62% of women murdered in 1987 were killed by their male partner. In the first 11 months of 1992, 415 women were killed in one Brazilian state - 70% by their male partners. 42 women were killed by their partners in Israel in 1991 and in Papua New Guinea almost 73% of women murdered between 1979 and 1982 were killed by their partner. The link is even stronger in India where it is believed that women are frequently killed, often for disputes over dowry. In 1990 the police recorded 4,835 dowry deaths in India - which they admit is a gross underestimate of numbers. Many of these are deaths from burning - being doused in

kerosene and set fire to being a common way of presenting the murder as a "kitchen accident'. (Heise, Pitanguy et al. 1994) These deaths can also be a way of getting rid of widows who otherwise would be an expense to the family.

There are other countries where, because women have almost no status at all, including some where the birth of female babies are not required to be registered, many women are completely at the mercy of the men in the community. Recent examples that have come to light are Saudi Arabia and Afghanistan.

The health consequences of domestic violence

The health consequences of domestic violence are not restricted to injuries sustained during an episode of violence. The effects can be severe and cause ongoing mental and physical disability. Although much of the research about the health effects and costs of violence against women comes from developed countries, clinicians and advocates in developing countries confirm that the women survivors of domestic violence experience the same negative outcomes in all countries where it occurs. (Heise, Pitanguy et al. 1994) (UNICEF 2000) Rape and domestic violence are a significant cause of death and disability among women of reproductive age in developed and developing nations. (Heise, Pitanguy et al- 1994). In the studies cited for this, maternal conditions, STD's and HIV are higher on the list of conditions causing disability and death. Many of these, however, are undoubtedly related to domestic violence, as it is known that abuse during pregnancy, partner rape and sexual abuse are common components of domestic violence. (Ward, Wilson et al. 1995). Maternal mortality is also a possible outcome of domestic violence. (UNICEF 2000)

Mental health.

This is discussed in chapter four.

Rape.

In America at least 40% of women who live with abusive men have had coercive sex. (Campbell, Alford 1989, cited in (Heise, Pitanguy et al. 1994). In Bolivia and Puerto Rico 58% of abused women report being sexually assaulted by their partners. ISIS International (1988), cited in (Heise, Pitanguy et al. 1994) Women who are raped and/or sexually abused by their partner experience many of the same problems as women who are date or stranger raped. These include gynaecological problems, STDs, HIV, sexual problems, unwanted pregnancy and consequently the effects of legal or illegal abortion.

There are also numerous psychological effects including nightmares, depression, an inability to concentrate, sleep and eating disturbances and feelings of anger, humiliation and self blame. These effects are reported to persist for several years after the rape/s. (Heise, Pitanguy et al. 1994; UNICEF 2000)

Effects of abuse during pregnancy

Abuse frequently begins or accelerates when a woman becomes pregnant. Walker (1979), cited in (Campbell 1984) Pregnant women who are abused suffer from depression, delays in prenatal care and miscarriage and their babies are likely to have low birth weights. (Elvidge 1997) (UNICEF 2000)

Injuries

New Zealand and international studies show that approximately a quarter of abused women require medical treatment for injuries that include lacerations, concussion, miscarriage, joint dislocation, puncture wounds, internal bleeding, genital injuries and head injuries. New Zealand studies of domestic violence found that 37% of abused women had scars caused by injuries, 74% of 582 recently assaulted women had visible injuries including bruising, lacerations, damaged teeth and/or fractures. Victims of domestic violence have the highest rates of internal injuries and unconsciousness of any assault victims. Assaults can result in loss or partial loss of hearing and sight, damage to internal organs, musculoskeletal disorders and other permanent disabilities. Burns can cause permanent disfigurement. Lentzner and DeBerry (1980) cited (Heise, Pitanguy et al. 1994)

Other long term effects include chronic pain, chronic headaches, gastrointestinal disorders, chest pain and palpitations, gynaecological problems, unwanted pregnancy, STDs including HIV, pelvic inflammatory disease, insomnia, asthma, irritable bowel syndrome, headaches, chronic pelvic pain and self harming behaviours such as smoking and unprotected sex. (Elvidge 1997) (UNICEF 2000) (Kemic, Wolf et al. 2000)

Alcohol and Drug Abuse

About one third of abused women will abuse alcohol and/or drugs. Miller (1990) cited in (Heise, Pitanguy et al. 1994) reports that domestic violence is the strongest predictor of alcoholism in women after controlling for income, violence in the family of origin and having an alcoholic husband. Prevalence rates range between 6% - 51% for women who go into refuge or who use domestic violence services. (Clark and Foy 2000) Other studies have suggested that most abused women only begin

drinking heavily after the abuse has started. Amaro et al (1990); Stark et al (1981) cited in (Heise, Pitanguy et al. 1994) Clinical populations of substance abusing women have been assessed for experiences of domestic violence. Prevalence rates of between 41% - 80 % have been found. (Clark and Foy 2000)

The effects on children

In New Zealand, over half of the children who go into a refuge with their mothers have suffered physical abuse themselves. 23% have been threatened with guns, 30% have been hit with furniture, 30% have been burned with cigarettes and 18% have been hit with bottles. Some children will also have been sexually abused (Elvidge 1997) Fanslow reports that there is a 30% - 60% overlap between abuse of adults and abuse of children in the same home - indicating that child abuse escalates with partner abuse. (Fanslow 2001).

Children who live in an environment where abuse is occurring suffer trauma whether or not they are abused themselves. The children's stability is threatened and this influences their sense of security and their ability to survive, which causes them lasting damage. Research indicates that boys who grow up with violence are six times more likely to be violent in their own adult relationships and girls from abusive backgrounds are likely to become abused women. Two studies show that children who witness abuse experience many of the same emotional and behavioural problems that abused children do, including depression, aggression, disobedience, nightmares, poor school performance and somatic health complaints. Davis and Carlson (1987); Jaffe et al, (1986); cited in (Heise, Pitanguy et al. 1994).

The prevalence of domestic violence in New Zealand

In New Zealand, best population estimates indicate that between 15% - 35% of women will be hit or forced to have sex with their partners at least once in their lives and 44% - 53% of women report having experienced psychological abuse in the previous twelve months. (Fanslow 2001) A Christchurch study found that 8.5% of mothers had reported one or more assaults by their husbands in a five year period and a Dunedin study of women's health found that 16.2% of women had been physically abused at some time as adults and 10% reported repeated assaults. (Mullen, Romans-

Clarkson et al. 1988) Leibrich found that 21% of men reported physically abusing a female partner in the last year and that there was a 35% life time prevalence. Cited in (Elvidge 1997)

The Dominion, a Wellington newspaper, reported that police were called to 209 domestic violence incidents in the 24 hours beginning Christmas morning, December 25, 2000. (Dominion 2000).

New Zealand Police statistics report that in 1998 police attended 21,297 domestic violence incidents, domestic violence related offences comprised 28% of all reported violence and 4% of all reported offences, there were nearly 10,500 domestic violence related prosecutions and police personnel spent nearly 200,000 hours on domestic violence incidents.

Since the Family Violence Database was started by the Police on February 1994, a total of 138,434 offences and incidents (To 31 December, 1998) were reported via the database. (Police 1999).

The Women's Safety Survey, 1996, surveyed 438 New Zealand women who were currently living with a partner and 71 women with recent partners, both Maori and non-Maori. Results include: 24% of the women with current partners and 73% of the women with recent partners reported that they had experienced at least one act of physical or sexual abuse by their partner. One in seven women currently living with a partner reported experiencing at least one act of physical or sexual abuse by their partner in the previous six months, this increased to one in four for Maori women. 44% of the women with current partners and 94% of the women with recent partners reported that they had experienced at least one type of controlling behaviour. Maori women were significantly more likely to report this than non-Maori. One in fifty women currently living with a partner reported that they had experienced ten or more acts of physical or sexual violence by their partner during the relationship. (Victimisation Survey Committee 1996).

Maori whanau violence is higher than family violence in non-Maori families and Maori women will receive higher levels of medical treatment and be more likely to be victims of repeat violence than non-Maori women. (Ministry of Health 1998) The National Collective of Independent Women's Refuges has reported that 45% of all women using refuge service are Maori women and 53% of the children using refuge services are Maori. NCIWR, 1997 cited in (Ministry of Health 1998). This may only be reported violence. It is probable that violence is more hidden in middle/upper socio-economic groups, but just as common as in lower socio-economic groups.

Domestic Violence and socioeconomic groupings in New Zealand

Although anecdotal evidence suggests that violence against women is more prevalent in lower socioeconomic groups of people, studies consistently show that violence occurs across all strata of society and all educational levels, although not necessarily at the same prevalence rates. (Heise, Pitanguy et al. 1994) There are a number of possible reasons for this. One may be that poorer people are more likely to involve the police, their houses are closer together and so neighbors can intervene, there may be less social stigma attached to calling in the police, lower socioeconomic strata may be studied more, they may access public rather than private health facilities and there may be (financially) relatively less to lose, for women, by leaving.

Domestic Violence - culture specific issues

Worldwide there is a widely diverse range of experiences of violence against women. Levinson (1989) identified 16 societies that can be called 'essentially free of family violence' and Sanday (1981) has found that there are societies free of rape. Both cited in (Heise, Pitanguy et al. 1994) One example is the Wape people of Papua New Guinea. (Counts 1990) Other societies practice endemic life threatening violence against women including among some peoples in Afghanistan, Saudi Arabia, Papua New Guinea and Bourgainville. Violence against women involves men having the power of life and death over women, for example in Afghanistan, female genital mutilation, proscribing what women can say and do in the name of religion and pack rape as a male cultural practice.

Even within cultures that overtly respect the rights of women to be safe and to retain bodily integrity there are frequently high rates of abuse. Women from a wide variety of cultures identify with the concepts and behaviors outlined above which constitute the range of behaviours used by men to control, and assume power over, women.

American empirical studies have shown that when socioeconomic factors are controlled for, no cultural differences are found in the incidence of domestic violence.(Cervantes and Cervantes 1993).

Heise (1994) presents a survey of domestic violence in 27 diverse countries of the world, incorporating developed and developing nations. (Heise, Pitanguy et al. 1994). In all of these countries there is evidence of extensive domestic violence among the surveyed populations. The survey details physical,

sexual and emotional abuse. This is reinforced by the UNICEF (2000) survey. (UNICEF 2000). This indicates that violence against women is a worldwide phenomenon.

> *Domestic violence or men's violence against women, is symptomatic of patriarchal hierarchical systems designed for men by men.* (Bames, Fleming et al. 1993) page 9

If this is true, then all patriarchal systems will exhibit similar controlling behaviours. Patriarchy can be defined as:

> *...any kind of group organisation in which males hold dominant power and determine which parts females shall or shall not play, and in which capabilities assigned to women are relegated generally to the mystical and aesthetic and excluded from the practical and political realms.* Adrienne Rich (1979) cited in (Campbell 1984) page 92

However, there are also issues, related to the oppression of women, that are specific to certain populations of people, and may be because of minority status, marginalisation, racial, sexual or economic oppression, lack of knowledge of the English language and homophobia. (Senturia, Sullivan et al. Undated)

Cultural Issues for women living in New Zealand

In 1992 Busch interviewed women who identify as Pakeha, Maori and Pacific Island about domestic violence. These women all have similar experiences of abuse. The patterns of abuse and the behaviours of the men are similar through all of the interviews. (Busch, Robertson et al. 1992)

Crenshaw (1994) discusses domestic violence as an intersection between gender and racism. (Crenshaw 1994) Maori, Pacific and other non-European women in New Zealand, because of the institutionalised racism inherent in our culture, are frequently poor, live in substandard, overcrowded houses and are either unemployed or in poorly paid jobs and lack job skills. They also have primary responsibility for their children and for other caring and church commitments in their communities. Women in this situation have fewer options when they are abused as they don't have the income to live

independently with their children, they have very few housing options and don't have friends who are in a position to shelter them.

Race and culture intersect to support domestic violence in a number of other ways. People in non dominant cultures are often hesitant to call the police or other government agencies because of a general unwillingness to subject themselves and their lives to agencies that are perceived to be hostile, especially when there are recent memories of war or social unrest. There is also a more generalised ethic against public intervention, which is the desire to keep the private world as a haven from the diverse assaults on the public lives of racially subordinated people. This desire to keep the personal private, and women's pride, may make it harder for a woman to seek protection and support. (Cervantes and Cervantes 1993) (Senturia, Sullivan et al. Undated)

Maori Women

For Maori women the experience of violence is similar to that experienced by any other abused women, in that the tactics and results of abuse fit the patterns identified above. Abuse of Maori women by their partners affects the women's ability to carry out their roles within the whanau - the extended family. This has effects and implications for not just the women and her children, but for the whole whanau and for future generations. (Ministry of Health 1998)

Maori believe that a causal and complicating factor of violence in interpersonal relationships is the history of colonisation and the far reaching effects this has had on the people - in particular its effect on identity and self worth. (Haimona, Henare et al. 1997)

As the Pakeha institutions increasingly replaced traditional Maori control, lore and structures, violence against women and children increased. At the same time, resistance against state control continued to grow. This has led to a situation where, because of wanting to remain shielded from state interference, Maori reaction to violence has become one of justifying or rationalising the violence away and "turning a blind eye", or even in many cases, incorporating violence into family life. *"We even have a trendy name, the 'Bash' that young people are using now, that makes violence towards women a normal part of life"* (Haimona, Henare et al. 1997) page 23. This means that, because women must make violence public before they can seek help and, because making violence public can often increase the negative experiences that occur both within and outside of the family, there is a great deal of pressure on Maori women to remain silent.

Pacific Women in New Zealand

Pacific Nation women are also unlikely to be supported if they publicly acknowledge abuse by leaving an abusive partner. The lack of support comes from at least two sources. One is the strong Christian ethic of many Pacific people, which supports women's subordination and gives tacit permission for men to 'discipline' women. The other motive is more related to the experience of living in a racist society. Many people believe that by acknowledging abuse in Pacific societies, that these communities will be further branded with allegations that they are violent, potentially reinforcing stereotypes used to justify oppressive police, child protection and other discriminatory practices. These concerns are well founded. For example, in 1992, Pacific people were accused of excessive child abuse, which also fuelled commentary about excessive rates of incest. The figures released by the Minister of Social Welfare were, however, miscalculated by 70%. It is, of course, the misinformation that is remembered.

Asian Women in New Zealand

Geeta Chaudhary says that domestic violence is as least as prevalent in Asian communities in New Zealand as in any other community, and seen in all forms used by men to gain power and control over women. Asian women are often constrained by their culture and religion from seeking help or leaving violent situations. They are also constrained by being immigrants and being fearful of and/or not understanding the New Zealand socio-political structure. Asian family structures are usually patriarchal, with women occupying a subservient position within the family. The rigid gender norms, combined with traditions of honour, prevent women expressing themselves as individuals. The norms also sanction abuse by minimising or legitimising violence against women. (Chaudhary 1997)

Issues for all immigrant women in New Zealand

Non-New Zealand born women face different issues than those of their New Zealand born relatives. Being an immigrant imposes barriers of language, lack of familiarity of services and sometimes implies that women have a more traditional understanding of women's roles and the options for ending abuse.

Having immigrant status makes women even more vulnerable to abuse. People must prove that they have been happily married for two or more years before they can get residency based on being married to a permanent resident. This means that many women will choose to stay with an abuser, rather than jeopardise their opportunity to become permanent residents. Immigrant women are generally more

isolated than New Zealand born women because of their relative lack of access to family, friends and traditional support structures. This frequently results in their being dependent on their husbands for information, including information regarding their legal status. Even after becoming permanent residents, women, because of isolation or lack of English, have limited access to information and can therefore still be threatened by their husbands with deportation and/or having their children removed. Being in a situation where one or other partner in the relationship does not have legal status in the community makes it even more impossible for a woman to seek help. Lack of English language has further implications for immigrant women, as they find themselves unable to articulate their situations once they decide to seek help. (Senturia, Sullivan et al. Undated) Many mainstream counselling and refuge services are loath to work with non English speaking women as they are not able to "understand the rules and join in the group therapy" (Bartlett 1996)

Aboriginal women

Indigenous Australian women are organising to address the issues of violence against women and children in their communities and families. Many of the issues that they are dealing with are relevant to New Zealand women, especially Maori, because of their Tangata Whenua status. Aboriginal women claim that:

> *... it is seen as unproblematic in the Black community for Black women to "talk up" about the injustices of the state. Talking about the bashings, rapes, murders and incest, for which Black men themselves are responsible... is seen as threatening in the extreme. The state has been the focus of Black grievances for so long that levels of Black on Black violence that exist in Aboriginal communities are overlooked as a secondary issue or else are portrayed solely as the dysfunction arising from colonisation by Europeans. Although contemporary Aboriginal violence most certainly has its roots in the genocidal dispossession of Aboriginal people from lands and political power, it cannot be left at that. Increasing numbers of Aboriginal -women...are beginning to talk openly about solutions to the violence that is tearing indigenous communities apart.* (Lucashenko 1996) page 380

This is an issue that is also currently relevant in New Zealand.

Lucashenko, (1996) carries on to say that using the "traditional law" argument to justify women's inferior status and the violence perpetuated on them cannot be justified. Indigenous society has existed in Australia for over 40,000 years. She suggests that it is difficult to see how any small scale and close knit society could continue to flourish under conditions that saw the current levels of rape, murder and child abuse as acceptable. Aboriginal women are now saying that they are being subjected to three types of law;

> *White man's law, traditional law and bullshit traditional law, the latter being used to describe a distortion of traditional law used to justify men's assault and rape of women and/or men spending all the family income on alcohol....* (Lucashenko 1996) page 383

Conclusion

This chapter has outlined a definition of domestic violence that includes mental, physical, emotional and spiritual abuse of one person by another with the intention of gaining total control over that other person. The range of behaviours involved in this process are outlined. This study focuses on physical, sexual, emotional and spiritual violence that is committed against women by men with whom the women have a sexual/domestic/intimate relationship and is based on the concept that men's power and control issues underlie the expression and direction of violence towards women and children. The usual pattern that is identified involves a combination of 'tactics' designed to exert power and control over one person, by another person.

The women being interviewed for this study use their own understandings of domestic violence. No definition has been imposed on participants.

The prevalence of domestic violence, both world-wide and locally, is examined, indicating that this is a problem that is extensive and not bound by any one culture, class or religious group - in fact, with a very few exceptions, this is a world wide problem. The major physical effects of abuse are outlined, including the effects on children. The chapter concludes with an overview of culturally specific issues for Maori women, women from Pacific Nations, Asian women in New Zealand and Aboriginal women with a focus on the intersection of racism and domestic violence and cultural expectations and domestic violence.

"It's her own fault – why doesn't she just leave?"

Ideas and theories about why women remain in abusive relationships.

Introduction

This chapter examines some of the theories that have been developed to explain why women enter, and stay in, abusive relationships. Many of these theories have focused on the behaviours and pathologies of the women being abused, without consideration of the structural, cultural and psychological effects of living in an abusive situation. There is also a list of more contemporary and practical reasons why women may choose not to leave an abusive situation. Following this there is a short discussion about the process, for women, of leaving and why asking the question "why doesn't she leave?" is not constructive within a discussion about domestic violence.

Different views

Over the years a wide range of ideas and theories have been propounded for why women 'seek out' and stay in abusive relationships. Many of the ideas that have been proposed have examined what is wrong with the women in the relationship, rather than looking at the behaviour of the abusing man. Other ideas have used the *"presenting characteristics or symptomology of these (abused) women, post trauma"* (post abuse), to explain the cause of domestic violence against them. (Koss, Goodman et al. 1994) page 34

Some of these theories are listed below:

Masochism

This theory suggests that women seek out, and remain in, abusive relationships because they enjoy being abused. This theory originates with Freud who posited that all women have masochistic tendencies. In 1964 a group of psychiatrists concluded, on the evidence of twelve case studies, that a husband's aggressive behaviour '*freed the masochistic needs of the wife and was necessary for the wife's equilibrium'*. Newburger and Bourne, 1964, cited in (Campbell and Humphreys 1984)

This theory was perpetuated in studies which proposed that women deliberately provoke men into hurting them, Faulk, (1974) cited in (Campbell and Humphreys 1984) and that physical fighting is necessary for true intimacy. Bach, Wyden (1969), cited (Campbell and Humphreys 1984) The fact that many women express love for their abusive partner is also taken as evidence of masochism. Walker, (1983), cited in (Koss, Goodman et al. 1994) Page 36

While there are some women who, for a number of reasons, provoke arguments and fights, this theory has been subjected to much criticism and is not in general use today. (Koss, Goodman et al. 1994)

Personality disorders

Some women in abusive relationships have been diagnosed as having a "*self defeating personality disorder*", also called "masochistic personality disorder". (Koss, Goodman et al. 1994)

Fulfilling traditional stereotypes

Women have been blamed for causing their partners to abuse them by either fulfilling or resisting culturally constructed sex role stereotypes. Star et. al (1979) label women immature for traits that are acknowledged prevailing cultural norms such as submissiveness and accepting male authority. Cited in (Evan Stark, Flitcraft et al. 1981) In contrast, Snell et al (1964) label a woman hostile, domineering and masculine for, for example, fighting back when hit and refusing to sleep with her husband when he is drunk. Cited in (Evan Stark, Flitcraft et al. 1981)

Being raised in an abusive situation, and therefore looking to replicate the experience

This theory suggests that family violence is transmitted intergenerationally, from battered children who become battered or battering adults. (Evan Stark, Flitcraft et al. 1981) It does appear that women who have been abused as children will have a higher than usual risk of becoming involved in adult relationships that are abusive. (Evan Stark, Flitcraft et al. 1981) (Koss, Goodman et al. 1994) What this does *not* mean, however, is that all women in abusive relationships have been abused as children. Various studies have identified respectively 33.3% of abused women having lived in violent homes as children (Roy) 23% (Gayford) and 29% (Dobash). All cited in (Campbell and Humphreys 1984).

Women are as violent as men

Steinmetz (1974, 1977) cited in (Campbell 1984) studied 57 families and concluded that men and women used approximately equal types and frequency of violence against each other in their relationships. These results do not appear to be studies of abusive relationships, however, as none of the couples described violence that could be described as battering or abusive. Steinmetz cites Gelles 1977 study of 80 non-randomly selected families as support for her beliefs about abuse of male partners. In this study 49% of men had used violence against their wives and 32% of women had used violence against their partners. The argument was undermined by the finding that 25% of the men used violence on a regular basis, compared to 11% of the women. Straus et al (1980), in a survey of 2,143 couples showed an equal number of men and women who had ever used violence in their marriage. Of these, however, only 0.5% of the men, in comparison to 7% of the women, experienced severe enough violence to be considered battering. This was explained by the men being more ashamed to disclose abuse and the women's lesser ability to do damage. All cited in (Campbell and Humphreys 1984)

To counter arguments that women are as abusive as men, Dobash and Dobash (1979) cited in (Campbell 1984) suggest that men use more severe forms of violence, a wider range of strategies and more use of threats of force than their female partners. A number of other studies also support this counter view. Levinger (1966); Gayford, (1979); Walker (1979) cited in (Campbell 1984) Studies also reveal that it is men who are likely to hit first. Hilbennan and Munson (1977-78); Dobash and Dobash (1979) cited in (Campbell 1984)

Co-dependency

Co-dependency is a concept that first gained credence in America to describe the behaviour of the partners of addicts who unwittingly supported the addictive behaviours of their spouse. The concept has been extended to cover almost all behaviours, including *"...battered wives (who) would frequently allow a husband addicted to violence back into the home, believing - or wanting to believe – his promises that abuse would never be inflicted upon them again."* (Stafford and Hodgkinson 1991) page 1-2. Co-dependents are *"relationship addicts"* (Page 3) and are compulsive in everything they do. Co-dependents *^actually project their own needs on to others"* (page 21) so, according to this theory, when an abused woman stays with an abuser it is because the abusive relationship is meeting her needs to control and manipulate others.

Some authors have taken this idea further to suggest that women who live in abusive relationships do it because of their own inadequacies. This understanding of domestic violence suggests that women have

to stop hoping that their partners will change and instead change themselves - because it is their attitude that is causing them to be treated abusively. (Norwood 1985)

Learned Helplessness

Walker (1979, 1984), cited in (Koss, Goodman et al. 1994) developed a theory called "battered women's syndrome". This theory explains that living in constant fear of violent attack and experiencing on-going physical assault from an intimate partner causes sufficient stress to affect women in a number of significant ways. The syndrome describes emotional, cognitive and behavioural reactions to abuse. It does not describe abnormal personalities or pathologies. The theory involves a concept of learned helplessness - the *"loss of ability to predict whether behaviours will have any effect on an outcome and corresponding restriction of 'behaviours*." (Koss, Goodman et al. 1994) page 83. Walker (1979, 1984). cited in (Koss, Goodman et al. 1994) posited that abused women's affective, cognitive and behavioural responses may become impaired because of their focused concentration on survival. They may also exhibit other behaviour such as hypervigilance, acquiescence towards the abuser, lack of trust and fearfulness resembling paranoia, denial of the seriousness of the abuse and an appearance of susceptibility to others.

Learned helpless is understood as the response of a person or animal to a situation of random painful experiences. The person becomes increasingly less motivated to end the pain and exhibits anxiety, depression and dependence. This in turn causes people to become passive, submissive and helpless. (Campbell and Humphreys 1984) It can also be conceptualised as beginning when repeated abuse, occurring at seemingly random times, cause the victim of the abuse to believe that she has no control over her life and well being and that there is nothing that she can do to bring about positive change or an end to the abuse. This eventually prevents the woman from attempting, or seeking, help or escape.

While this view is still held by some people who work with abused women, it has been widely criticised. People do not appear to criticise the understanding of the behaviours that women manifest in abusive situations. Some critics, however, contend that the apparent helplessness of women may in fact reflect the lack of options and resources available to abused women, and the inadequacy of the services that do exist for them. (Koss, Goodman et al. 1994) Others have noted the persistence and resourcefulness of women trying to escape abusive relationships. (Koss, Goodman et al. 1994)

Other Reasons

Other reasons given for women staying in abusive relationships are that:

• The people/services that they access for help are not useful or forthcoming - or at times encourage her to stay. This includes families, friends, churches, mental health services and social services agencies. (Campbell 1984) (Personal Communications with police and court staff in Auckland) (Church 1984) (Ulrich 1998)

• There are no viable alternatives. Many women have no money of their own, no supportive family and friends to turn to, and no way of accessing alternative housing on their own. (Campbell 1984) (Elizabeth 1999)

• The woman knows or believes that if she leaves, her partner will find and kill her. (Campbell 1984) (Mullender 1996) Often the most dangerous time for a woman is after she has left the relationship. Women who live in abusive relationships generally have a very realistic understanding of how dangerous their partner is and will know whether or not it is safe to leave or to instigate action to stop the abuse. Browne, (1987); Dutton (1992a); Mahoney, (1991), cited in (Koss, Goodman et al.1994)

• The woman believes that it is best for her children if she stays in the relationship. This is a frequently heard sentiment in the media, the church and other arenas. As most women want the best for their children they endure abuse rather than break up the family (Church 1984) *"...For instance, good mothers are supposed to facilitate access to fathering by staying together, but good mothers are also required to protect their children from harm... "* (Elizabeth 1999) page 3

• The woman believes her partner when he says he will reform. The cycle of abuse frequently includes periods when an abusive partner will apologise for his behaviour and promise to change. Because of their love, their sense of responsibility and their desire to keep the family together or because he says he loves her, many women will want to believe that their partners will change. (Campbell 1984) (Church 1984)

• The woman knows or believes that her partner will take her children away from her. This is a particularly effective threat when the woman is isolated from outside information and/or she does not speak English as her first language. (Personal Communications with police and court staff in Auckland) (Mullender 1996)

• That women have internalised the myths about domestic violence and do not believe that they have a right to leave. (Campbell 1984)

• Women believe that the abuse is their fault. This is because their partners tell them this all the time, and never take responsibility for their own behaviour. (Church 1984) (See also the explanation of 'minimising, denying and blaming' in the description of abusive behaviours. Chapter 1)

• The psychological state that the women are in after experiencing sustained abuse prevents them being able to take action or organise an escape. (Personal Communications with police and court staff in Auckland)

• Very low self-esteem is one consequence of living in an abusive relationship. This feeling of low self-esteem makes it difficult for a woman to end or leave an abusive relationship (Aguilar and Nightingale 1994)

• The women are so coerced by their partners that any mental energy that they have left is *"channeled into the efforts of basic survival, thereby eliminating any chance of independent growth and development. "* (Avni 1991) Page 147 Avni describes coercion as the man not giving his partner freedom, not letting her express herself, not giving her room to move and not giving her space to do even one thing she wants to do.

• Women are kept prisoner by their partners. (Avni 1991)

Leaving is a process

For many women in abusive relationships, leaving is not a simple, single event. Women often need to go through a series of processes before they are ready to move out for good. Ulrich (1998) suggests that the stages women go through involve changes in their awareness of themselves in the abusive relationship. " *The increased self awareness may be the result of adaptive coping responses or of personal learning."* (Ulrich 1998) page 71.

As seen in the reasons listed above, leaving can be a complex process that women have to negotiate. Ulrich has identified *"Economic support,... support services,... filing assault charges,... getting a restraint order, ...safety,... personal growth, (and)...previous separations"* as being helpful to women in their decision to leave a violent relationship. (Ulrich 1998) page 72

Professionals who work with abused women talk about "*practicing leaving*", a process that can be protracted, as abused women develop strategies, confidence and networks. (Bartlett 1996)

Conclusion

This chapter has given an overview of the main theories that have been developed to explain why women stay in abusive relationships and the counter arguments to some of the better known theories. Theories such as those relating to masochism or the fulfilling of traditional female stereotypical roles place women in no-win situations. Within these theories, women are blamed for the abuse that they are experiencing - whether they fulfill or resist traditional expectations of female behaviour.

The concept of learned helplessness further belittles women, discounting the strength they show living in an abusive relationship and denying the attempts they have made to resist or leave the situation. It does, however, acknowledge that the behaviours women manifest as a result of being abused are a response to abuse - rather than signs of mental illness - even although most of the behaviours can be viewed as symptoms of personality disorder, an axis two DSM IV diagnosis.

The chapter points out that leaving an abusive relationship is a process that can take a long period of time, as women in these relationships take time to recognise their situations, gather the resources needed to leave and then practice leaving. They also, usually, have a realistic understanding of the risks to themselves and their children if they leave and therefore need to plan carefully to minimise these risks.

Over all, examining why women stay (in abusive relationships) is not constructive for two major reasons.

• It blames the victim of the abuse, rather than looking at the pattern of abuse as practiced by the perpetrator.

• It devalues the effects of the abuse that the woman experiences and re-reads these effects as causation.

These two responses mean that women are frequently denied the help that they require to leave, or recover from, domestic violence.

> *Psychological theories that blame the victim and protect the assailant - for example, the view that the battered wife needs and provokes the abuse for masochistic reasons – contribute to the problems of battered women. These mythical but widely held clinical beliefs result in misdiagnosis, inappropriate treatment and failure to protect the victim.* (Russo 1985) page 10

Martin et al (1998) point out that while there is, within most (western) communities, a condemnation of rape and partner abuse, and calls for punishment of the offender, there is often an unwillingness to recognise the pervasiveness of violence and the number of women who experience it in some form. They believe that *"...this 'pathologising' of violence leads to a search for aetiology* (causation) *within the individual... instead of questioning the level of violence endemic in our society "* (Martin, Morris et al. 1998) page 157

It is not necessarily constructive to examine why women stay in abusive relationships, as often they are only staying because they see no viable alternative. It would be more constructive to examine why and how men abuse, and how women and children survive and escape this abuse. More importantly, we must ask ourselves why we still live in a society that allows the abuse of women and children to continue, with only a small percentage of the population acknowledging the abuse, and working for change.

Society teaches and reinforces the behaviours women and men manifest. Therefore, it is cultural conditioning that allows men to abuse women and women to take responsibility for it. Until we, as a society, challenge this and teach men to be non-abusive and to take responsibility for their own actions - and the outcomes of their actions - we will continue to perpetuate these behaviours.

Mental illness

Introduction

Mental illness is a concept that can be described from a number of different models and perspectives. Many people, including those who have been most influential in the development of a western understanding of mental illness, have attempted to define mental illness and the parameters for diagnosis and treatment. This chapter, therefore, does not attempt an analysis of what mental illness is. What it does do, is to list two common usage definitions and discuss mental illness from three perspectives. There is a brief examination of mental illness from a gender analysis perspective – including a post modern viewpoint, an overview of mental illness from a Maori perspective and a discussion about the DSM IV - the diagnostic tool most often used for the assessment of people who present to New Zealand Mental Health services.

Definitions of mental illness

The definition of mental illness used by the New Zealand Mental Health services is from the Mental Health (Compulsory Assessment and Treatment) Act 1992. It says:

> *Mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it; (a) Poses a serious danger to the health or safety of that person or of others; or (b) Seriously diminishes the capacity of that person to take care of himself or herself; and, mentally disordered, in relation to any such person, has a corresponding meaning.* (New Zealand Government 1992)

This is similar to the definition used by the American Surgeon General, which reads:

> *Mental illness - the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterised by alterations in thinking, mood or behaviour (or some combination thereof) associated with distress and/or impaired functioning.* (Department of Health and Human Services 1999)

Gender Differences in Mental illness

One of the ways that the concept of mental illness can be examined and investigated is that of the gender differences and similarities inherent in people's experience of mental health and illness.

Epidemiological studies conducted in various parts of the world since World War Two have consistently found gender related differences in the rates of mental illnesses and in the ways men and women experience their illnesses. There are two overarching theories about why there are gender differences in psychiatric disorder – biological and psychosocial. (Romans 1998)

Biological

This theory focuses on women's reproductive hormonal functions – primarily premenstrual, menstruation, menopause, pregnancy and post-partum hormonal changes. The primary reason for studying these functions is because this system is totally unrelated to male physiology. Other hormonal systems have also been studied. No definitive links between hormonal function/fluctuations and mental illness have, so far, been identified.

Psychosocial

This theory examines the conditions of people's lives - including socioeconomic circumstances, education, employment, general health, adversity, the experience of violence, child-raising, and personality. Studies that examine life circumstances do find a relationship between such things as social disadvantage, isolation, disability and psychiatric illness. (Romans 1998)

This avenue of study is particularly relevant to women, as currently women are more likely than men to head one parent households, to have to truncate their education and employment for child-raising, to experience poverty and to be the victims of sexual and domestic abuse.

Postmodern

In postmodern discourse, mental illness can be conceived of as being located either within a material/bodily/realist perspective - mental illness as biochemical, hormonal, physical responses to stimuli, or from a language/discursive perspective, which is concerned with the cultural and communicative aspects of the body, virtually unrelated to the biological processes. A discursive perspective argues for an understanding of mental illness that is deconstructive. This approach

theorises that labels such as schizophrenia and depression are social categorisations placed on sets of behaviours that deviate from the 'healthy norm' and are a pathologising of those behaviours that threaten the status quo and the power and/or peace of the dominant social groups - within the parameters of present knowledge.

Ussher (1997) argues that to locate mental illness within this debate, a middle way must be found - one that acknowledges that people do live in/experience their own material circumstances as well as the socialisation and inculturation of their upbringing.

> *To understand phenomena such as ... madness ... we need to examine both bodily processes and practices and the ways in which these processes and practices are constructed in the realm of the symbolic. We cannot separate the two.* (Ussher 1997) page 7

Stoppard, (1997) further illuminates this debate with her investigation of two contemporary approaches to explaining women's depression, encapsulated in the expressions “women's lives” and “women's bodies”.

The “women's lives” approach encompasses the social circumstances of women's lives including gendered sources of stress and their impact on women. This approach derives from sociological and feminist investigations into the relationship between women's everyday experiences, the systemic inequity they are constrained by, and their reports of psychological distress. Psychotherapy models of treatment are associated with this understanding of depression.

A “women's bodies” approach focuses on the biological body, with particular emphasis on women's reproductive capacity. It is part of the bio-medical model of understanding health and illness. Treatment for depression that is understood as biological is predominantly psychotropic drug therapy. (Stoppard 1997)

Maori Concepts of Mental Health

For Maori, mental health is part of the overall concept of health that is explained by, among others, the model of Te Whare Tapa Wha - the four cornerstones of the house. This model incorporates te taha hinengaro - mental health, te taha tinana – physical health, te taha wairua - spiritual health and te taha

whanau the health of the family and the environment a person lives in. Within this model, mental health is only one part of a whole person and is not able to be separated out from the other circumstances of a person's life.

Mason Durie has identified that, for Maori, mental and physical health cannot be separated and that, when looking at the wellbeing or illness of a person, the whole person - and their family and cultural history - must be taken into account.

> *Mental health is more complex than a series of disorders that are subject to curative treatment... Good Maori mental health is more than efficient health services. It demands that the institutions of society are nurturing, that families, whanau and communities are strong and supportive and that the policies and laws of the nation are consistent with the dignity of individuals.* (Durie 1997) page 108

He also believes that good health, for Maori, is strongly linked to people having a well developed sense of personal and cultural identity, including access to cultural determinants such as language, knowledge, land, institutions and society. (Durie 1996)

Many Maori reject the concept of mental illness, some referring instead to a transgression of tapu or a makutu - a curse placed on a person by the evocation of spirits. There is also a much greater acceptance of difference in most Maori communities, which recognises aberrant behaviour, but does not label it as mental illness. This is not necessarily positive - as it means that people often don't get the help and support that they require until they are really unwell. (Dyall 1997).

This approach differs markedly from the medical/western model which describes mental illness as being solely a disorder of the mind or moods, generally unconnected to physical and spiritual health or to the environmental and family events that an individual is involved in.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. (DSM IV)

This section gives a brief overview of issues from the DSM IV, pertaining to the diagnosis of women, who are experiencing domestic violence, with a mental disorder.

The DSM IV, (1994) definition of mental disorder begins by stating that:

> *.... the term mental disorder unfortunately implies a distinction between 'mental' disorders and 'physical' disorders that is a reductionist anachronism of mind/body dualism. A compelling literature documents that there is much 'physical' in 'mental' disorders and much 'mental' in 'physical' disorders. The problem raised by the term 'mental' disorders has been much clearer than the solution.* (American Psychiatric Association 1994) page xxi

The definition then given is that a mental disorder is:

> *...a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress...or disability... or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expected and culturally sanctioned response to a particular event, for example the death of a loved one. What ever its original cause, it must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the individual. Neither deviant behaviour (e.g. political, religious or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a dysfunction in the individual as described above.* (American Psychiatric Association 1994) page xxi

Discussion then ensues about how to use the manual, referring to the need for clinical judgment in the use of the classifications, as mental disorders do not fit comfortably into discrete categories and to remind people that everyone with a similar diagnosis will still, however, be a "heterogeneous"

individual. Two other points worth noting from the introduction to the manual are first, the comment that *"...a diagnosis does not carry any necessary implications regarding the causes of the individual's mental disorder or its associated impairments. Inclusion of a disorder in the Classification (as in medicine generally) does not require that there be knowledge about its etiology* (causation)... " (American Psychiatric Association 1994) page xxiii The other is the reminder to incorporate an awareness of ethnic and cultural considerations into the use and interpretation of the classifications. I would assume, since ethnicity and culture are included, that an equivalent reminder be made about gender. Gender, however, is not referred to.

Physical and sexual abuse of an adult are listed only as coding notes, specifically to be used "*when the focus of clinical attention is severe mistreatment of one individual by another*". There are no definitions given of abuse or explanations of the possible symptomology that victims may present with. It is almost the same for 'Relational Problems'. Partner relational problems are included when patterns of interaction between spouses are *"characterised by negative communication, distorted communication, or noncommunication that is associated with clinically significant impairment in individual or family functioning"*. (page 681). Relational problems are included because they may *"exacerbate or complicate the management of a mental disorder...may be a result of a mental disorder...may be independent of any other conditions, or can occur in the absence of any other condition"* (page 680) (American Psychiatric Association 1994)

The description of Post Traumatic Stress Disorder includes, as possible causation, violent personal assault. Under 'Associated Features', domestic battering is mentioned - along with a range of other possible symptoms, (page 425) (American Psychiatric Association 1994)

Critiques of DSM IV

There are many criticisms of the DSM IV. The following critiques relate primarily to the relevance of this method of classifying illness to women's lived experience.

There are a number of people who have criticised the medicalisation of mental illness, especially as it relates to women. Russell (1986) believes that the values underlying the DSM work in various ways against the interests of women. This is because of the focus of mental illness as either just a product of the mind, or of the body - with no examination of a woman's social/family environment. (Russell 1986)

Others support this concern. Usher believes that the DSM categorisation is based entirely on what can be measured or observed, which reinforces the focus on material phenomena and causation. Mental illness, within this model, is perceived as being from the body - from hormones, germs etc. (Ussher 1997)

Russell questions the concept that a "*pathological condition*" can be diagnosed when the "*etiology is unknown*". She points out that a "*...person may be experiencing an abnormal and debilitating state without it being appropriate to describe her experiences as symptoms."* (of a mental illness). (Russell 1986) page 85.

Carmen et al also question this concept.

> *Biological, endocrinologic and genetic factors, as presently understood, are not sufficient to explain gender differences in depression. There are however a lot of things that directly or indirectly impact on it... physical and sexual abuse, sexual harassment, sex discrimination, childbearing and child rearing, unwanted pregnancy, divorce, poverty and powerlessness.* Carmen, Russo, Miller (1981) cited in (Russo 1985) page 10

There are a number of diagnoses in the DSM IV that are dependent on the evaluation of the psychiatrist to decide if the behaviours being examined are symptomatic of a mental illness or not. Russell (1986) contends that many of these are in fact value and moral judgments, based on the psychiatrist's own sex role and other socialisation. Because of this, judgments are subjective and, if "etiology" is not to be taken into account, women's own understanding of why they are distressed or behaving in an unusual way may not be given credence. (Russell 1986)

Conclusion

The researcher has an understanding of mental illness that is explained by a combination of the Maori holistic concept of health and the gendered analysis described. This means that mental illness is perceived as a reaction, by an individual, and/or a social/cultural grouping of people, to processes such as stresses, personal circumstances, loss, alienation, lack of identity, violence, trauma and a host of other experiences, both current and historical. This analysis of mental illness also encompasses

physical and spiritual causation. The analysis includes issues of gender, as the gender structure of our society privileges the experiences of men and therefore makes women specific issues invisible or unimportant. Hence the need for this research.

The women being interviewed used their own understandings of mental illness. No definition has been imposed on participants.

The mental health effects of domestic violence

Introduction

This chapter first examines the prevalence of a history of physical and/or sexual abuse among people who experience mental illness. It then lists the most usual psychiatric effects of domestic violence, discusses how these may not be symptoms of mental illness, but a reasonable response to abuse and trauma and then looks at how a diagnosis can have a negative and stigmatising effect on a woman who is labeled mentally ill. Finally this chapter briefly examines issues related to women with a suspected mental illness entering a woman's refuge.

Background

> *In New Zealand it is most likely to be married women who require treatment for mental illness.. women suffer, in significant numbers from problems associated with social factors such as marital problems.... New Zealand culture places special stress on the training of women (and the socialisation of them) for the role of wife and mother. The women who suffer from mental illness in New Zealand are not those women who have stepped outside that role, but rather those women who have accepted it and attempted to live within its confines.* (Calvert 1978) page 8

When Sarah Calvert wrote this in 1978, women in New Zealand were beginning to challenge the accepted role of traditional homemaker and explore issues relating to women and women's place in the community. It would therefore be reasonable to assume that, given the changes that have occurred over the years, that living with a male partner would no longer be a cause of stress sufficient to cause women to seek mental health service help. This is not the case however. Marital difficulty is the most commonly reported event in the six months prior to onset of depression and the most frequent problem presented and discussed by depressed women in outpatient treatment. (Russo 1985)

One of the major marital difficulties related to presentation at a mental health service is that of being in an abusive relationship. Warshaw (1993) cited in (Davies, Harris et al. 1996). Abused women are

reported to be five times more likely to use psychiatric services than non-abused women. (Elvidge 1997) Abused women comprise a significant percentage of suicide attempts, psychiatric patients and alcoholics. They make repeated visits to medical and psychiatric services for problems that are related to their abuse but which remain unrecognised and unacknowledged as being abuse related. (Evan Stark, Flitcraft et al. 1981)

Avni, (1991) studied women, in Israel, who had experienced extreme jealousy, isolation and virtual imprisonment by their partners. She notes that:

> *Since the husband's suspicions have no basis in fact, the mere raising of them makes her feel wronged. The mental coping with the discrepancy between the accusations and the actual situation is very difficult and undermines her sense of reality, so much so that in certain situations she begins to doubt her position and consequently her sanity. The brainwashing makes her doubt herself.* (Avni 1991) page 145

One of the women quoted in the study talks about her experiences of this process in the following way.

> *I didn't know what to think, because things (accusations of betrayal) were not true. Sometimes, because he kept saying "you were unfaithful, you were unfaithful," I used to say to myself: Maybe I really did it without being aware of it. The things I got into my head! I was going crazy.* (Avni 1991) page 145

The prevalence, worldwide, of a history of childhood and adult physical and/or sexual abuse among people who experience mental illness

In the last twenty years there have been many studies about the relationship between (usually) childhood abuse and psychopathology in adults. (American Medical Association 1996) This research indicates a clear relationship between the severity of the abuse and the likelihood of adult psychopathology. A study of people with severe mental illness reported - for women - lifetime physical abuse rates of 71% and 57% lifetime rates for sexual abuse. Ritsher et al, (1997) cited in (Read and Fraser 1998)

Many studies suggest that these numbers are under-reported, as the numbers increase when people are directly asked about their experiences. (Roberts, Williams et al. 1998) (Wurr et. al. 1996); (Jacobson et. al. 1987) cited in (Read and Fraser 1998) Jordan and Walker report that in a study of mental health intake procedures, twice the number of clients disclosed abuse in response to a structured interview that included questions about victimisation, rather than in response to a standard intake interview. This study of outpatients found that 68% had experienced major physical or sexual assaults or both, but that 71% of those patients had never before disclosed the abuse to a clinician. (Jordan and Walker 1994)

In a New Zealand setting, Mullen (1988) used a random selection of women from the community to assess both the level of psychiatric symptomatology and the incidence of sexual and physical abuse as children or adults. This study identified that women with a history of abuse in either childhood or adult life were significantly more likely to have raised scores on (both) measures of psychopathology and to be identified as psychiatric cases. 4.6% of the subjects reported being sexually abused as adults. Adults were defined in the study as over 16 years old. These women had significantly raised scores on both of the psychopathology measuring tools. 20.1% of the women identified themselves as having being physically abused as an adult, in a domestic/intimate partner relationship. These women also had significantly raised scores on both psychopathology measures. Many of the women had never previously disclosed abuse and the researchers believed that the abuse disclosed was generally under-reported. (Mullen, Romans-Clarkson et al. 1988) This indicates that a history of abuse contributes to the general level of psychiatric illness experienced by women in the community.

The prevalence, in New Zealand, of a history of adult physical and/or sexual abuse among people who experience mental illness

In a 1998 study. Read reported a 22% rate of adult sexual or physical abuse among people who had experienced mental illness. This was taken from medical records, not from direct questioning. (Read and Fraser 1998).

Coverdale and Turbott (1999) carried out a controlled study that compared psychiatric out-patients with a matched group from the community. The results showed that, compared to the controls, people who had experienced mental illness were significantly more likely to report a history of sexual or physical abuse as adults (over 16 years old) - with women being more likely to have been abused than men. They provide a number of explanations for this finding. One is that people who experience mental illness have some impairment that renders them unable to avoid circumstances of risk. The second is

that the abuse precipitated the mental illness. An alternate explanation is that, because of poor socio-economic circumstances, people who have experienced mental illness may live in situations that expose them to higher risk of assault and other abuse. (Coverdale and Turbott 1999)

The prevalence of psychological distress and physical illness, related to domestic violence, in New Zealand

Nickolaos Kazantzis et al (2000), studied the prevalence of psychological distress and physical illness, related to domestic violence, among women in New Zealand. They surveyed 961 women aged between 19-90 years old. Their findings indicate that not only did domestic violence significantly increase the risk of psychological distress and physical illness among the women participating in the study, but that it was the most important factor. They believe, from this study, that domestic violence may account for as much as 12% of psychological distress and 7% of physical illness among adult women in New Zealand. They also discovered that the association between domestic violence and mental or physical illness and distress can persevere for a long time after the abuse has ended. Very few of the women in the study had told a medical or mental health professional about the abuse that they were experiencing. The conclusion reached from this research is that *"this is compelling evidence that heightened attention towards screening for domestic violence within the health system, and an increasing emphasis on those attending mental health services, is required."'* (Kazantzis, Flett et al. 2000)

The mental health effects of physical assault

Physical assault can destroy the perceived unity of our minds and our bodies. Drucilla Comell (1995) addresses the issue of the fragmentation of self that can result from an assault situation. She says:

> *In cases of physical assault ones sense of projected unity is completely shattered. Physical violence imposes a horrifying dualism of self. In a violent assault we are reduced to somebody: as other to our body"* (Cornell 1995) Page 43. She also says *"Therefore to protect ourselves from threats to our bodily integrity we have to protect the future into which we project our unity and have our bodily integrity respected by others."* (Cornell 1995) Page 40

One of the problems for a woman in an abusive relationship is that she cannot "protect the future" as she has very little control over which reality will be presented to her day by day, moment by moment. Her sense of bodily integrity becomes increasingly under threat and unstable as her sense of control is decreased.

Elaine Scarry (1995) makes this point when she insists that violent assaults on the body always imply an attack on the conditions under which the self has been constituted and thus through which it could be reconstituted. This representation of the body as apart, as 'made up' out of parts is further described in her discussion of torture:

> *...For what the process of torture does is to split the human into two, to make emphatic the ever present but, except in the extremities of sickness and death, only latent distinction between a self and a body, between a me and my body. The self or me, which is experienced on the one hand as more private, more essentially at the centre, and on the other hand as participating across the bridge of the body in the world, is embodied in the voice, in language. The goal of the torturer is to make one, the body, emphatically and crushingly present by destroying it, and to make the other, the voice, absent by destroying it."* (Scarry 1995) page 48 - 49

Other methods of abuse can also cause this destruction of the self. This is the purpose of abuse - to destroy the will so as to render it pliant and acquiescent. The Man Alive Class Manual (1995) Chapter 1, describes this process.

> *Male - role control works by coercion. Men violate their partners to coerce them into control. Male - role control works by physically, verbally or emotionally destroying your partner's physical, intellectual and emotional integrity so that she will be afraid to be herself, will control herself, and therefore be available to be controlled by you.* (Man Alive 1995) page 41

The costs of domestic violence

The costs of domestic violence are documented in a number of studies. Looking at the mental health service costs, the American Medical Association include not only the cost of mental health and

substance abuse services, rehabilitation and long term care but also the cost of the inappropriate care of unrecognised mental health problems. There are also less overt costs such as years of life lost because of suicide and homicide, the time that people are unable to function without support, diminished realisation of educational, employment and personal potential and the long term effects on the family and the community. (American Medical Association 1996).

Moss reports that abused women are prescribed anti psychotic drugs, pain medication and tranquilisers three times more than non- abused women. Moss, 1991, cited in (Everingham 1999).

The psychological effects of domestic violence

The following is a list of some of the most common psychological effects of domestic violence.

Suicide

Abused women are more likely than non-abused women to exhibit suicidal behaviour. (Dutton 1992) Studies from around the world put the statistics of suicide related to domestic violence at: 1/4 of suicides of women in America, 1/2 of all suicides by African American women and 41% among Fiji Indian women. Counts (1987) posits that in some African, Oceanic and South American societies, female suicide operates as a culturally recognised behaviour that enables the politically powerless to revenge themselves on those who have made their lives intolerable. She includes examples from Africa, Peru, Papua New Guinea and the Melanesian Islands. Counts, (1987) Cited in (Heise, Pitanguy et al. 1994)

Stark, (1981) reports that female suicide attempts and domestic violence have been associated in the psychiatric literature, but that the link has been explained by women's assumed predisposing traits - such as rigid personality or general hostility - which make these women unable to cope with family tension. (Evan Stark, Flitcraft etal.1981)

She suggests however, that domestic abuse is the most frequent precipitating cause of female suicide attempts when family conflicts are present and that this also precipitates depression and general hostility. Stark, (1979) cited in (Evan Stark, Flitcraft et al. 1981) (Kemic, Wolfet al. 2000)

Alcohol abuse.

About one third of abused women will abuse alcohol or drugs. (Heise, Pitanguy et al. 1994) Domestic violence is the strongest predictor of alcoholism in women after controlling for income, violence in the family of origin and having an alcoholic husband. Miller, (1990) cited in (Heise, Pitanguy et al. 1994). Other studies have suggested that most abused women only begin drinking heavily after the abuse has started. Amaro et al (1990); Stark et al (1981) cited in (Heise, Pitanguy et al. 1994) (Roberts, Williams et al. 1998) (Dutton 1992)

Mental illness diagnoses

Women who have been abused are commonly diagnosed as suffering from major depression, trauma and anxiety disorders. (Gleason 1993) (Roberts, Williams et al. 1998) (Dutton 1992) They are given diagnoses such as eating disorders, generalized anxiety, obsessive compulsive disorder, multiple personality and personality disorders. (Koss, (1990, 1993), cited in (Davies, Harris et al. 1996) (Kemic, Wolfet al.2000)

Other presenting issues associated with victimisation may be: sleeping disorders, self-neglect, malnutrition, panic attacks, aggression towards ones-self and/or others, dissociative states, repeated self injury, chronic pain, compulsive sexual behaviours, sexual dysfunction or pain and poor adherence to medical recommendations. (UNICEF 2000) (Dutton 1992; Gleason 1993)

Post traumatic stress disorder

Judith Herman (1997) posits that there are similarities between *"…rape survivors and combat veterans, between battered women and political prisoners, between the survivors of vast concentration camps created by tyrants who rule nations and the survivors of small, hidden concentration camps created by tyrants who rule their homes."* (Herman 1992) page 3. She claims that established diagnoses of women, such as borderline personality disorder, multiple personality disorder and somatisation disorder have failed to recognise the impact of victimisation and abuse on women and she makes a case for a new diagnosis of complex post traumatic stress disorder. This diagnosis is for victims of prolonged repeated abuse.

She argues that women who live/have lived in abusive situations will frequently respond to their situations as soldiers or captives will. Some will fight and retain a sense of internal integrity and connectedness; others will eventually become immobilised by fear and their inability to positively

influence their situations. Those who capitulate to the situation will usually suffer more severe trauma responses. (Herman 1992)

Ward et al. (1995) state that the strengths of this concept are in the linking of consequences of violent victimisation by a male partner with the consequences of victimisation from other sources, thus legitimising the responses. They point out, however, that the concept of PTSD does not account for all abused women's reactions. (Ward, Wilson et al. 1995)

Symptoms that are caused by violence are described as feelings of intense fear, total helplessness, fear of complete destruction, profound emptiness and/or total dislocation. (Dutton 1992) (Harris and Dunsmore 1999)

Co-morbid psychiatric disorders.

Domestic violence may aggravate existing psychiatric disorders and women with histories of mental illness may find their complaints of abuse mistakenly regarded as delusions or other evidence of their illness. (American Medical Association 1996)

The effects of being abused may not be mental illness but a reasonable response to abuse

Evan Stark (1995) believes that psychiatric researchers fail to understand the appropriateness of observed responses in abused women and support sex role stereotypical assumptions about women's behaviour. (Evan Stark, Flitcraft et al.1981) This belief is reinforced by Ward et. al.(1995) who states that "It *is crucial that mental health professionals understand the cultural and social context of domestic violence (and sexual violence) and do not pathologise women."* (Ward, Wilson et al. 1995) page 27

Physical and sexual abuse has profound implications for an abused person's mental health. Abused women exhibit a wide range of emotional and behavioural symptoms as a result of repeated abuse. These responses include a range of coping strategies that may change over the duration of the abuse and may continue to be utilised long after the threat of violence has gone. (Ward, Wilson et al. 1995) Practitioners often misinterpret these behaviours as signs of mental illness in a victim rather than as a response to protracted physical and psychological danger. (Russo 1985) When one individual uses

intimidation and coercion to control other people in the family it is often the victim(s) who will appear symptomatic, but this is best understood as an attempt to deal with a horrific situation. (American Medical Association 1996)

A coping model perspective on women's responses to domestic violence is critical to understanding the development and continuation of behaviours that may seem, to the onlooker, to be self defeating or pathological. Coping strategies, both psychological and physical, represent women's attempts to manage intolerable, frequently life threatening, situations and to make sense of the situations they find themselves in. (Ward, Wilson et al. 1995)

Characteristic symptoms, seen in all people experiencing traumatic life events, include symptoms of fear and stress, hyper-vigilance, the re-experiencing of the trauma and/or emotional numbing. These are natural reactions, much as fever, elevated white blood cell count and activation of the immune system are responses to infection. When the trauma is especially intense or chronic or the person has become worn down and weakened, the usual coping strategies can be overwhelmed and may be replaced by more drastic survival mechanisms such as increasing submissiveness, increasing social isolation or substance abuse. (American Medical Association 1996)

> *This present study found that violence intensifies psychological dysfunction and that battered women appear similar to schizophrenic women on a major clinical diagnostic tool. Battered women are also frequently misdiagnosed as borderline personality disorders...research on domestic violence needs to explore the impact of violence on mental health... We need to question how psychiatric labels are being applied to victims of violence, further victimising them. Sadly this process highlights the failure of the mental health profession to understand that illness lies less in the individual than in the society.* (Rosewater 1990) page 214

Institutional abuse

> *An abused woman's crisis results not just from the abuse she is suffering but also from the disruption to her basic social and cultural expectations. Violence disrupts a woman's values about relationships, child raising, families and marriage and also the place of the society to protect these institutions and values.* (Hoff 1992) page 145-146

Each time a woman is abused within the confines of her home or family, and the abuse is minimised, ignored or justified by the protectors of the community values, her fundamental beliefs and understandings are challenged and disrupted. It also places the responsibility for the abuse on the abused woman, rather than on the abuser. Lack of response from police, courts, nurses, doctors, families and churches, i.e. all of the places women seek help, exacerbate women's distress and her feelings of helplessness. (Hoff 1992) (Busch, Robertson et al. 1992)

Differences between being given a diagnosis of a physical illness and a psychiatric illness

The consequences of being labeled mentally ill are often greater than a label of a physical illness (although there are exceptions such as epilepsy.) This is caused by a number of things including the stigma attached to the mental illness label and also that people who have a diagnosis of mental illness usually have far more ongoing contact with medical services than those who have acute physical illness. Therefore the quality of service has more impact on people who use psychiatric services, because they have more, and longer, contact. (Rogers and Pilgrim 1993) (Patten 1992)

The stigma associated with mental illness.

People respond to mental illness in a culturally determined way. In New Zealand our images of people who have mental illness are that they are likely to be violent, dangerous and unpredictable - or unable to cope with even the basics of living and caring for children. People have a feeling of unease and awkwardness about people with mental illness and don't want them living near by. There is also a degree of sympathy and concern. (Patten 1992; Ng, Martin et al. 1995)

One of the damaging aspects of being given a diagnosis of mental illness is the stigma attached to that label. In New Zealand, the stigmatisation of people who have a mental illness has been identified as one of the barriers to such people achieving wellness and equitable participation in the community. People who are mentally ill are likely to be compromised in their attempts to achieve rehabilitation and social integration and may be less likely to establish supportive relationships. (Herd 1994) Some people with mental illness believe that the effects of stigma are worse than the illness itself, as the discrimination which is associated with the negative stereotyping makes access to goods and services, housing, jobs, community organisations, education, welfare and physical and mental health services more difficult. (Torry 1994) (Pulice, McCormick et al.1995) (Rogers and Pilgrim 1993)

Thompson and Thompson (1997) identify the consequences of discrimination, related to the stigma of mental illness, under the following headings: degradation, scapegoating, mystification, shame, de-humanisation, denial of access to goods and services, inadequate health care and invisibility. (Thompson and Thompson 1997)

This stigma often results in women receiving less than adequate care and services from the agencies that they have gone to for help. This compounds the lack of care and understanding that abused women frequently encounter when they ask for help to ameliorate abusive situations. Sandra, an abused woman, became *"physically, emotionally, mentally drained...my head was going around and around... I had to get out and get some space. I had to get back on track..."* (Busch, Robertson et al. 1992) page 73. She admitted herself to a psychiatric ward where she stayed for about six months. This was held against her by her lawyer - who subsequently didn't believe what she was saying about her own safety and the safety of the children - and the Family Court, which resulted in Sandra having problems gaining legal custody of her children. (Busch, Robertson et al. 1992)

Women with a mental illness entering a woman's refuge

Robyn Palmer (1996) carried out a study of the incidence of women with a mental illness entering a woman's refuge. She found that when refuge workers discovered that women had a mental illness their response was to feel that the refuges were being used as "dumping grounds" for the women. The staff felt under-resourced and lacking in the necessary skills required to work with the women and in many cases were afraid of them. They were also very uncomfortable about having medication on the premises. (Palmer 1996)

Refuges do not generally take women who they know have drug and alcohol or mental health problems. This is because these women require more intensive and skilled care and are disruptive towards the other women in the house (SAFTINET 1998) Robyn Palmer elicited comments such as *"they frighten other women", "it's added strain on an already difficult situation", "disastrous"* and *"women have their own problems and difficulties without having to cope with the extra pressure of someone's behaviour that seems weird.* (Palmer 1996) page 19/20

There are also concerns about the effects on children of having these women in the house, including fear of violence and the children being frightened. Agencies such as Saftinet - the Auckland Domestic Violence Centre - screen for signs of mental illness and drug and alcohol abuse and if they suspect it will often tell women that they are unable to help them. (SAFTINET 1998) Refuges also screen. *"...we have a screening process which eliminates women with a mental illness as refuge is an inappropriate place for them, e.g. not 24 hour care".* (Palmer 1996) page 18

Some refuges will take these women, especially if they have developed a relationship with the relevant mental health/drug and alcohol services. This relationship can also be used to get rid of women, *"...we use them when a women has been admitted ...it's usually very clear that she can't stay in the refuge"* (Palmer 1996) page 22

For most women, if they do gain access to a refuge, their experience is frequently that they are quickly moved on or moved out.

Suggestions for the kind of help and support these women require from a refuge, includes 24 hour care with trained, paid, professional staff, with adequate provision for the care of the women's children.

The lack of understanding of the intersection between need and service provision for women with mental illness requiring refuge is clearly illustrated in this quote from a National Collective of Independent Refuges publication about improving outcomes for women and children using refuge services. The entire section titled Mental Health reads:

> *Refuges are experiencing increasing demand from women with mental health issues who are isolated from skilled, professional assistance. Both statutory and non-statutory organisations attempt to use Refuge as accommodation for women who are not facing family violence issues but are homeless and may have drug and alcohol addictions or even be suicidal. Mental health is often perceived as the "Cinderella" of all health, which adds further to costs for refuge, through inappropriate and misleading referrals for safe housing. Refuges are careful to screen women for appropriateness of service, however there is often no alternative available care or emergency housing* (Price Waterhouse Coopers 2000)

There is no mention of the mental health effects of domestic violence, or of the service needs of women who feel that their partners have driven them mad.

Conclusion

This chapter has discussed some of the more common psychiatric effects of domestic violence. These symptoms are the same as those exhibited by people who are victims of other forms of trauma and abuse including war, rape, being held hostage and being an assault victim. It then examines how these may not be symptoms of mental illness but strategies that an abused woman uses to cope with the abuse she is experiencing. Having these responses to abuse can be very disorientating to a woman, causing her to access mental health services for respite. These services, however, rarely ask about why she is experiencing the symptoms she exhibits and instead diagnose and treat her as requiring not safety, but drugs and therapy. This pathologising of symptoms further disempowers a woman and also further undermines her sense of reality - already shaken by the abuse she is experiencing.

The chapter also discusses the effect that the lack of response, by health and other agencies, can have on a woman. It seems reasonable to hypothesise that if every person a woman attempts to contact minimises or denies her reality, then this will add to her feelings of unreality about the situation she is experiencing, and will make it even more difficult for her to leave that situation.

There is a discussion about the stigma and discrimination that is experienced by people who have been labeled mentally ill and demonstrates how having a diagnosis of mental illness can increase the difficulties a woman has in being seen as a credible witness to her own experience, and in having her abuse recognised and acted upon.

Finally the chapter discusses the issue of women with perceived mental illness accessing refuge services.

Mental Health Services Response to Domestic Violence

Introduction

This chapter examines the mental health services response to women who either present with symptoms of abuse or who disclose domestic violence. It examines women's perceptions of mental health service staff and mental health service staff knowledge about, and response to, disclosure of domestic violence. It also looks at the relationship this has with enquiries about childhood sexual abuse. The chapter goes on to discuss responding to women who have been abused and who are in contact with mental health/drug and alcohol services. Finally the chapter addresses issues related to the training of mental health professionals and finishes with an examination of mental health service policies relating to domestic violence.

Mental health service staff knowledge about, and response to, disclosure of abuse

Kurz and Stark identified three barriers that affect the health sector response to women who experience domestic violence. These are;

> *...myths and stereotypes that fail to acknowledge the role and responsibility of health professionals intervening in cases of violence; the sexist structure of the health system which has tended to ignore and minimise the health needs of abused women; and the structural constraints and fragmentation of the health system that inhibit an effective response,* Kurz and Stark (1988) cited in (Davies, Harris et al. 1996) page 21.

Wayne Miles, the head of mental health services at Waitemata Health suggested that the primary reason that mental health services staff don't ask about abuse is that they feel that there is nothing they can do about it and therefore, it is no use asking. (Miles 2000)

Read (1998) studied the responses of staff, in an Auckland psychiatric inpatient unit, to disclosures of abuse. One hundred consecutive admissions were examined and measured in terms of:

• acquiring information about previous treatment for, or disclosure of, abuse
• whether counselling, support or information was provided
• if abuse was reported to the legal authorities
• if people were referred for ongoing counselling.

The results of the study indicated that there were thirty two people documented as having disclosed abuse, none of whom had documentation relating to receiving support, counselling or information while in hospital and only three referrals were made for counselling after discharge. (Read and Fraser 1998)

> *In several cases the abuse being recorded and then ignored was recent or ongoing. One file recorded a recent gang rape by gang members. The current partner of another patient was described as …"a violent man who has beaten her up often and severely". The notes of another woman state "beaten up many times"'... "When my husband is beating me up I get mentally ill". Another patient …"claimed that her husband was assaulting her and her children".... "If she would not perform her chores her husband would beat her". In none of these cases is there any record of any action, legally or therapeutically being taken, or considered. In the last case the woman was discharged to the home of the alleged perpetrator.* (Read and Fraser 1998) page 210

None of the abuse was reported to the authorities.

> *That so few of those whose abuse was actually known about received what most mental health professionals would regard to be an adequate response to the disclosure of abuse is a matter of grave concern, particularly when that disclosure took place in a mental health setting.* (Read and Fraser 1998) page 211

Read and Fraser hypothesised, from these results, that the low staff response was not unique to the particular service evaluated. Instead, this particular service would have been assumed to be more sensitive to disclosures of abuse as the entire staff had been involved in the development of policy about the issue. They also suggested, based on a previous study (Read and Fraser 1998) that the

amount of disclosed abuse was under-reported, compared to that which would emerge if proactive enquiry was engaged in.

Saunders et al. (1989) in a study of mental health intake procedures estimated, through the use of structured interviews about abuse, that twice as many clients experienced abuse as those identified in a standard intake interview. Jocobsen (1989) found that 71% of abused patients had not disclosed abuse until they were specifically asked. Both cited in (Jordan and Walker 1994)

A New Zealand study (Agar and Read 2000) evaluated the responses of community mental health outpatient service staff to disclosures of abuse. This study found that 12 of the 92 clients who had been identified as having been abused as children or adults received therapy within the mental health service and 15 were referred to outside agencies. Of the 12 clients who received therapy within the service, 3 received therapy that was identified as abuse focused, 2 received partial abuse focused therapy, and 6 of the clients received therapy that did not address the issue of abuse at all. It is noted in the study that this is a better response than that achieved by (NZ) inpatient services, where only 9% of those with a known abuse history received any support or therapy during or after their hospitalisation.

The reporting of abuse to the police or other authorities is *"rarely even considered by New Zealand mental health authorities, even when the abuse is recent or ongoing"*. (Agar and Read 2000) page 14

Sex role stereotyping affects mental health service staff responses to abuse

Bemardez (1985), has examined the way that mental health professionals ignore both women's socialisation and the social milieu of a woman's life and relationships when diagnosing - and how sex role stereotypes can be used to define women as maladaptive or mentally unwell. She says that women are made responsible for their problems through a *"diagnosed deficiency, when her ailment is really a symptom of her adaptation to a world that has pathogenic expectations about her."* (Bemardez 1984) page 22.

She expands this idea when she says:

> *I have seen enormous damage done to women because of the emphasis placed on responsibility for pathology that they did not in fact have, when the origin of the problem is really in the world around them.* (Bemardez 1984) page 19

This follows a discussion about how women, by stepping outside of the subservient parameters of female socialisation, can be perceived as mentally ill. She ends with an example of a woman being hospitalised, in a mental health facility, because her husband had beaten her up. Her husband stayed at home!

To ask or not to ask?

In 1993, the "People First" survey was carried out in Britain by Rogers, Pilgrim and Lacey. This survey discovered that only 10% of people who had a diagnosis of mental illness described their problems in mentally ill terms, with 48% giving an explanation of a more personal or contextual problem such as marital problems or work stress. They found that these people expected their life experiences to be considered and, in fact, thought them crucial in diagnosing their problems. The experience of the people interviewed, however, was that their own understandings of their illness or its causes was not of importance to their clinicians. Cited in (Lothian and Read 2000)

These findings are backed by Agar (2000) who reports that in a New Zealand survey of mental health service users, 78% were not asked about abuse histories during initial assessment. The clients spoken to in this study felt that the failure to ask about abuse negatively affected the dialogue between them and their clinician, especially any discussion about causative relationships with their illness. In this study, 60% of the clients were unsure whether mental health workers saw a connection between their mental illness and their experience of abuse and only 17% felt that the connection was recognised. 69% of the people surveyed believed that there was a connection between their experience of abuse and their subsequent mental illness. (Agar, Read et al. 2000) Lothian (2000) reports the comments of research participants, when asked about the connections between past abuse and mental illness and whether or not clinicians should ask about it. These comments include:

> *The multiple abuse which followed went on and on whist I was going in and out of hospital. All of this (and the lack of professional counseling) has had immense ramifications.*

My life went haywire from thereon in...I just wish they would have said, "what happened to you " - but they didn't.

I think there was an assumption that I had a mental illness and - because I wasn't saying anything about my abuse I'd suffered...no-one knew.
(Lothian and Read 2000) page 8

Childhood Sexual Abuse Enquiry

There is an established relationship between childhood sexual and physical abuse and adult psychiatric problems. The numbers of sexually abused mental health service clients, are estimated at between 40% and 50% of the male and female client population. Physical and emotional abuse raises levels to 60 - 70%. (Young, Read et al.2000)

A New Zealand study, (Young, Read et al. 2000), asked 63 psychologists and 51 psychiatrists about their likelihood to ask clients about childhood sexual abuse when assessing them, the reasons that they would not ask, and the time that they think it is most appropriate to make the enquiry. The reasons given for not inquiring included that it was not an appropriate time to enquire as there were more pressing needs and concerns and/or that the clients would find the enquiry too distressing or that it would cause a deterioration of their psychological state. There was also a percentage of respondents who felt that there was a risk of false reporting or that the enquiry would generate false memory syndrome. Most of the surveyed professionals felt that the enquiry should be made at the first meeting, unless the person was too distressed. Others felt that rapport needed to be established first.

Women's perceptions of mental health service staff

Many abused women perceive mental health workers, particularly doctors and psychiatrists, as inappropriate to intervene in situations of domestic violence because of their traditional medical response of treating the victims of domestic violence as mentally ill, labeling them as psychotic or hypochondriacs and prescribing tranquilisers. Worchester (1992) states that *"medication and victim labels reinforce* (an abused) *woman's feeling that she is the problem and may contribute to depression, drug and alcohol abuse and suicide attempts."* Cited in (Davies, Harris et al. 1996) page 21. Abused women often refer to interventions such as the prescribing of medication including tranquilisers, and

referring abused women for psychiatric assessment, as examples of revictimisation by the system. Urbanic, Campbell and Humphreys, (1993) cited in (Davies, Harris et al. 1996) Being identified as mentally ill further lowers women's self esteem, making the process of leaving an abusive relationship, or recovering from one, even more difficult.

Responding to women who have been abused and who are in contact with mental health/drug and alcohol services - client response issues

Russo claims that when a woman enters a mental health service she should have a developmental history taken, especially to inquire about whether she has ever been subject to abuse. (Russo 1985) This requires the development of service protocols and standards of practice to guide this process. (Currier 1996) It also means that whatever treatment is being initiated for mental illness symptoms, it is important that there is ongoing assessment of a woman's safety. This incorporates, among other things, where she will live, the support services available to her, her ability to make decisions about her safety and the management of her children and their ongoing safety. It is also important that she is offered, and encouraged to access, specific services that help her to escape or deal with the abuse she has experienced - for example, support groups, women's refuge etc. Because a woman who has been/or is being abused needs to be able to realistically assess safety and respond accordingly, medications that impair her ability to do this should be prescribed with caution. (American Medical Association 1996)

National training and development issues

> *The prevention of sexual and physical abuse is an essential element of any national program aimed at promoting mental health and preventing mental illness.* (Russo 1985) page 12

An American study surveyed 221 psychiatric residents at four US medical schools about their training and experience in recognising domestic violence and providing treatment and referrals. Only 28% reported receiving training in the area of domestic violence. Almost half of the surveyed people said that they asked less than a quarter of their female patients about abuse. Fifty-nine percent of the respondents asked about abuse only when they suspected a problem. (Currier 1996)

UNICEF (2000) believe that all professional associations are key players in opposing violence against women. They suggest, therefore, that such organisations build domestic violence and human rights curricula into their professional training, and that professionals in the field receive training in these areas. They also recommend the development of protocols for identifying and referring cases of domestic violence to the appropriate bodies, including screening for detection and early identification. These protocols must be developed in collaboration with experts from the domestic violence field. (UNICEF 2000)

Health practitioners are well placed to provide a range of services for abused women. The American Medical Association guidelines suggest that this can include:

• Primary prevention - educating patients about the cycle and progression of domestic violence and making routine enquiries about any violence in the home.

• Secondary prevention - making patients aware of the health practitioners interest in hearing about abuse by providing posters and other material in the waiting room, routine enquiry and screening and having information about community services that are available for ongoing help.

• Tertiary prevention - providing medical care, identifying and referring for mental health disorders, monitoring of ongoing care plans and notifying statutory agencies when necessary.

• Advocacy - this may include encouraging changes in health care provision, criminal and civil proceedings and legislation, supporting improved funding for specialist agencies, and working for changes to the conditions that foster violence. (American Medical Association 1996)

Women who have been abused do not usually have symptom pictures that fit neatly into diagnosable categories. Therefore the emphasis should be on the identification of abuse, the assessment of the danger and the urgency of the situation, and the development of a treatment plan including referral to the appropriate agencies and resources. (American Medical Association 1996)

WHO believe that training about domestic violence should, where possible, be integrated into an existing professional curriculum rather than be created as a separate programme. They have identified the following issues as critical to a training programme to sensitise health care providers. These are:

- *their possible negative feelings including inadequacy, powerlessness and isolation, particularly in areas with few referral services.*
- s*ome cultural beliefs including the idea that domestic violence is a private matter.*

• *possible misconceptions about victim-survivors, including the belief that women provoke violence.*

(UNICEF 2000) page 18

In New Zealand, Read, (1998) suggests a number of training areas that need to be addressed in order for staff to appropriately ask questions about abuse. It is assumed that the issues would be addressed in the context of accepted policies and procedures and standardised processes, and after protocol about responding to disclosures of abuse have been established.

He suggests that training will need to include an examination of:

• why staff don't want to ask about abuse
• the myths and stereotypes about abuse and abused people
• information about the relationship between abuse and mental illness
• the relevance of asking in a psychiatric setting
• that men *and* women need to be asked
• how to ask about abuse
• what to do when abuse is disclosed. (Read and Fraser 1998)

New Zealand Mental Health Services policies

A review of mental health services planning documents identifies only one reference to domestic violence. This occurs in the North Health document "Mental Health in 2010 - a vision of the future for all people in the Northern Region" (1994) This document enumerates services for *"People who have experienced life crisis or trauma for example ... victims of...sexual or physical abuse"* (Northern Regional Health Authority 1994) page 38.

Otherwise domestic violence is not mentioned in any of the documents I reviewed, as follows:

• Mental Health Commission. New Zealand's Mental Health Strategy - Review of Progress 1994 - 1999 (1999)
• Mental Health Commission. Annual Report for the period ending 30th June 1998 (1998)
• Mental Health Commission. Blueprint for Mental health Services in New Zealand. Working document (1997)

• Ministry of Health. Moving Forward - the national mental health plan for more and better services (1997)

• Ministry of Health. Psychiatric Disorder and Treatment Seeking in a Birth Cohort of Young Adults (1998)

• Ministry of Health National Mental Health Standards (1997)

I have also spoken with the Mental Health Commission and they are unaware of references to domestic violence in any government mental health publications. There are, currently, no specific policies about domestic violence in Auckland Health Care, South Auckland or Waitemata mental health service's policies. (2001) John Read, a lecturer in psychology at Auckland University, wrote to over 100 mental health services in New Zealand asking for policies about domestic violence and sexual abuse. He did not receive any. There were no policies written down and it appeared that no organisation asked specific questions about violence. (Read 2000)

It would appear from this survey that domestic violence is not considered to be an issue for mental health professionals to take into consideration when developing services or assessing and treating people who present to their services. A phone survey of Auckland Health Care, Waitemata Health and South Auckland Health elicited the information that only National Women's hospital and the emergency department at Middlemore have any policy about screening for, and responding to, domestic violence.

Conclusion

This chapter has examined the mental health services response to domestic violence and historical child sexual abuse. The literature suggests that most mental health professionals have not had training about this issue and do not feel comfortable asking about it. Clients, on the other hand, feel that many of their mental health problems are related to the life experiences that they have had and indicate that they would like to be asked about abuse.

Current data indicates that if abuse is not identified and recorded at the time of a client's first admission to a mental health service, then it is unlikely to be identified at all. (Agar, Read et al. 2000) This suggests mat mental health service staff need to:

• be trained how to enquire about abuse at the time of first contact

• to intervene appropriately in domestic violence cases and to disclosures of past abuse
• have knowledge of the community networks and services available to women who are in abusive relationships
• have knowledge about how to ensure that the abuse issues that are identified are validated and followed up.

If staff in mental health services are not aware of a woman's abuse, and more specifically, if they have no understanding of the implications of the abuse on the woman's mental health, they risk treating her presenting symptoms, without ascertaining or addressing one of the major causes. They also are unable to put plans into place to ensure her ongoing safety. Assessing a women's history of abuse allows clinicians to place this information alongside the other data that has been gathered and, hence, to make a more accurate diagnosis, deliver more appropriate treatment and make plans for the woman's immediate and ongoing safety. Given the constraints on mental health services, this is not only ethically sound, but also makes financial sense. (Currier 1996)

More specifically, assessing and planning for women's ongoing safety impacts on prescribing practices. If mental health service staff are aware of a woman's need to be alert to danger in her home, they should not be prescribing drugs which will slow her reactions or dull her thinking.

Screening and assessment, combined with an in-depth knowledge of the psychological manifestations of domestic violence may also prevent many women entering mental health services as long term clients. If a woman is assessed as suffering from the effects of living in an abusive relationship she may find herself referred to more appropriate services - i.e. specialist domestic violence services, rather than remaining as a client of a mental health service.

The physical health service's response to domestic violence

Introduction

Health professionals offices and emergency departments are places that abused women often present with a range of problems related to domestic violence. Many patients report that they are willing to discuss these issues with a health care provider, but would prefer to be directly asked, as they have become used to keeping their abuse private. Unfortunately, doctors and other health practitioners are rarely trained to identify and manage cases of partner violence and therefore, rarely ask about it. (American Medical Association 1996)

This chapter gives an overview of issues related to the disclosure of abuse to physical health services/practitioners and also outlines three initiatives that have occurred in New Zealand in response to the need for a proactive system to identify and respond to domestic violence**.**

Health professional's untrained response to abuse

As a group, health professionals do not believe that they see many people who are in abusive relationships. A survey of doctors' perceptions of the incidence of male initiated domestic violence among patients in a number of California Emergency Departments was 0.04 per 1000. FUND (1995), cited in (Elvidge 1997) This is similar to the incidence found in a survey of GP's in Wellington in 1995. Kljakovic, (1995), cited in (Elvidge 1997). These low numbers of reported incidences are challenged by studies where doctor's perceptions of numbers of clients who have been abused are matched with patient interviews or patient records. When this is done, an average of 25% of patients are discovered to be experiencing partner violence. Abbot et al (1995); Drossman et al (1990) cited in (Elvidge 1997) A four year epidemiological study at the Royal Brisbane Hospital Emergency Department found that one in five women had a history of domestic violence. (Davies, Harris et al. 1996)

It appears that the main reason that health professionals believe that there is a low incidence of domestic violence among their patients is because they don't ask about abuse and because the health

sector environment does not encourage patients to disclose their domestic circumstances. (Fanslow 2001) Two New Zealand studies indicate that doctors routinely diagnose and treat severe depression, anxiety, sleeping disorders and eating disorders without asking about cause. Howden-Chapman (1994); Hetrick (1995) cited in (Elvidge 1997)

Disclosing to doctors may not increase a woman's chances of obtaining appropriate help and support. New Zealand and Australian studies indicate that in many cases, after disclosing abuse to their doctors, women feel worse. Howden-Chapman (1994); Hetrick (1995); Taft, Head (1995) cited in (Elvidge 1997) This is, in part, because of the demeaning labels that are used to describe abused women and the judgmental and insensitive attitudes that they encounter. Drake, (1982); Goldberg et al, (1984); Kurz, (1987); Ryan and King (1992), cited in (Davies, Harris et al. 1996) It may also be because of the inappropriate responses that women experience after disclosure.

Not being asked about abuse, or receiving an inappropriate response, may also be because of the preconceptions of health service staff about people with mental illness. Larkin et. al., (2000) report that in an American urban emergency department, where an intervention was put in place to screen for possible domestic violence, that people who were identified as psychiatric patients were significantly less likely to be screened than non psychiatric patients. Cited in (Larkin, Rolniak et al. 2000)

Health professionals internalised barriers

Studies of health professionals have identified a number of internalised barriers to addressing the issue of domestic violence with women. These are:

- fear of offending the patient
- fear of vulnerability caused by identifying with the patient's personal background
- frustration and feelings of inadequacy when they are asked to fix the problem
- loss of control - primarily from their frustration at not being able to control the patient's behaviour
- lack of time
- feeling inadequate about intervening.

(Sugg and Inui 1992) Ryan et al (1992) cited in (Davies, Harris et al. 1996)

Other barriers include *"...lack of training and information on the prevalence and impact of family violence, lack of formal protocols and institutional support for responding, ...and lack of confidence in referral agencies."* (Fanslow 2001) page 5

What women want from health professionals

Howden-Chapman (1994) and (Hetrick 1996) surveyed women who had experience of domestic violence and asked them what they wanted from their doctors. The results showed that women wanted doctors to initiate a conversation about abuse. Other studies identify that 78% of primary care patients favour routine enquiry about domestic violence. Friedman (1992) cited in (Elvidge 1997)

Hetrick's study of 56 abused women found that 80% of these women wanted to be asked about abuse, 90% wanted to hear the doctor say that abuse was wrong and that they did not deserve to be abused, 93% wanted to be given information about support agencies and their legal rights and 95% wanted to be referred to specialist agencies. (Hetrick 1996) Having a health professional express disapproval of abuse has been identified by women as critical to enabling them to take action to deal with their abuse. Taft and Head, (1995) cited in (Elvidge 1997)

Maori Women

A consultation was undertaken in 1994 to assess Maori women's specific needs in relation to disclosure of abuse to a GP. The information gathered from this consultation indicates that Maori women would not choose their GPs as a first contact point to discuss abuse, but would rather go to whanau and friends. GPs were perceived as racist and/or not conversant with tikanga, especially issues such as whanaungatanga, respect and the multidimensionality of health.

Features that would make a GP approachable include friendly reception staff, quality (i.e. un-rushed) consultation time, non-judgmental attitudes and knowledge of support structures. In order to encourage discussion of abuse a doctor should be encouraged to ask open ended questions about a woman's home life, help her develop a safety and action plan and offer ongoing help and guidance. It was also suggested that Tohunga should be recognised as valid and respected referral people for women seeking help and support. (King and Matthews 1994)

Women from Pacific Nation Countries

The information specifically formulated for the health sector about how to constructively respond to the needs of Pacific women indicates that the first challenge for the health sector is to acknowledge how widespread and severe the problem is. The next is to investigate ways the secrecy and shame that surround the public disclosure of abuse, and any other issues that interfere in disclosure, can be overcome. Lastly, appropriate services and procedures must be put in place to ensure that any intervention is constructive and appropriate. (FVPCC 1993)

Encouraging the possibility of disclosure

Pacific women in New Zealand have identified a range of issues that prevent the disclosure of domestic violence in a health setting. Some of these are barriers felt by many abused women, some of them are culturally specific. The things that most impede the disclosure of abuse for Pacific women are:

• not being given enough time to build trust with the health professional
• not being given enough time to talk
• being treated for symptoms not cause, i.e. being given tranquilisers for marital problems or being treated for injuries without being asked how the injuries occur
• being afraid of bringing shame to the family or having the family being split up
• having language difficulties
• feeling that doctors and health professionals are too important to listen to personal problems.

(Jefferson and Elvidge 1996)

These issues can be overcome by:

• being sensitive and showing interest in each woman
• asking direct questions about abuse
• considering the woman's culture, ethnic background and her whole life circumstances rather than seeing her as "an Islander"
• understanding her loyalty to her family and to her partner
• creating a safe, welcoming environment for her and getting interpreter help for her if she has language difficulties.

(Jefferson and Elvidge 1996)

Health sector initiatives in New Zealand

Ministry of Health Guidelines, 1998

In 1998 the NZ Ministry of Health published a set of guidelines to encourage government agencies to develop and implement a common policy approach to domestic violence. The policy states that:

> *Health and disability support providers can make a key contribution to achieving the Government objective (reducing family violence) through prevention strategies, improved identification and service responses to people experiencing domestic violence....they (the policies and guidelines) are an important step in ensuring that people affected by family violence obtain effective, appropriate health and disability support services, including identification, assessment, treatment and prevention measures.* (Ministry of Health 1998) page iii

The guidelines outline seven principles and standards that cover the key elements of a *"...comprehensive, effective, high-quality health and disability support service response to family violence."* (Ministry of Health 1998) page 9

The principles are:

> *Principle 1. Health sector providers will develop family violence protocols, procedures and policies to ensure best practice.*
>
> *Principle 2. Family violence protocols will be consistent with legislation*
>
> *Principle 3. Health and disability providers will be appropriately trained to respond to family violence.*
>
> *Principle 4. Effective and comprehensive community and hospital-based services will be available to family violence victims and abusers.*
>
> *Principle 5. The health and disability sector will provide a co-ordinated, culturally effective response to family violence.*
>
> *Principle 6. Health and disability services will provide a timely, quality response to family violence.*

Principle 7. Strengthening public health action on preventing and reducing the prevalence of family violence and abuse.

(Ministry of Health 1998) pages 10 – 32

These principles and the related standards enable any health or disability organisation to develop protocols that will identify abuse, safeguard the victims of abuse and put systems in place to enable the service to refer both the abused person(s) and the abuser to the relevant services. The document includes suggestions, key issues and information about the needs of different population groups. It also includes examples of existing protocols and intervention models. The Ministry of Health has recently appointed a woman to work with the health sector to oversee the development of policy.

Roberts et al recommend that all courses for health professionals, undergraduate and postgraduate, include training about domestic violence and that protocols are developed in all health settings to ensure that this knowledge about domestic violence is put into practice. (Roberts, Williams et al. 1998) The New Zealand Ministry of Health has started the process by releasing the guidelines, but there needs to be a commitment made to ensure that the rest of the process occurs.

General Practitioner Partner Abuse Project

A protocol of intervention in domestic violence was developed for use in general practice and was trialed with 26 General Practice doctors (GPs) in Auckland in 1995/96. The purpose of the project was to improve the GPs ability to intervene early in suspected cases of abuse by identifying stress symptoms and therefore helping to prevent injury.

The GPs received an initial 10 hour training with two 3 hour follow-up sessions over six months. The training concentrated on improving the GPs ability to recognise symptoms of abuse, to intervene and to refer appropriately. All GPs who took part in the trial were provided with dictionaries of local referral information, abuse awareness pamphlets for their patients and posters indicating their training and interest in assisting with the issue of domestic violence.

The feed back from the GPs who took part in the trial was very positive. They particularly appreciated having permission to ask about abuse when they suspected it. They also mentioned an increased

understanding of power and control and that this helped them identify the non-physical components of abuse. They all reported an increased confidence in dealing with domestic violence.

The main difference was not in the identification of increased cases of abuse, but rather in improved services for the identified cases, including increased referrals to specialised support and refuge services. The GPs also reported large numbers of information pamphlets about domestic violence being taken from the waiting rooms. (Elvidge, l997)

Community Alcohol and Drug Initiative

In 1996, staff at the Auckland Community Alcohol and Drug service (CADS) began to realise that many of the women who were self referring for help with their own or their partners drinking were involved in abusive relationships. Because the CADS policy is to provide services not only for those people who are substance abusers, but those who are affected by it, they set up a support group for partners of men who abuse substances and are violent to their partners. The groups reduced the social isolation of the women and helped to empower them to make safe and healthy choices in their lives.

> *The beauty of the group is how these women challenge each other in a way that we* (Alcohol and Drug Counsellors) *can't. It's amazing. As a spin off, we have found that women are less dependent on drugs and alcohol as a way of coping. Once the women deal with the violence and abuse issues it is much easier to address their own substance abuse. They find healthier ways to cope.* Justine Harris, CADS worker/group facilitator. (Elvidge 1997) page 6.

This service has been discontinued.

Middlemore Hospital Emergency Department Protocol

In 1993, in conjunction with the Injury Prevention Research Centre, Auckland, Middlemore Hospital Emergency Department trialed an emergency department protocol of care, OASIS, (Injury Prevention Research Centre 1996) for the identification and treatment of women abused by their partners. The protocol has been formally evaluated (Injury Prevention Research Centre 1996) The evaluation helped

with the development of the process, ironing out the bugs and reporting the success of the trial. The protocol has now been adopted as standard practice by the emergency department.

A staff nurse acts as the resource person for the protocol which is included in the orientation pamphlet and training for new staff. The OASIS protocol consists of five steps for staff to follow when assessing and treating women who may have been abused. These are:

> ***O****bserve women for clues suggesting abuse*
> ***A****sk women who are suspected of being abused about physical and sexual abuse*
> *ASsess risk of suicide, homicide and risk to children.*
> *Document all physical injuries.*
> ***I****ntervene by providing information about the cycle of violence, assisting women to identify existing support systems and consider overnight admission to the emergency department.*
> ***S****upport and refer to appropriate agencies.* (Injury Prevention Research Centre 1996)

Initially it was intended that all women who presented at the emergency department should be asked about physical and sexual abuse. This was modified, so only those who are suspected of being abused are asked these questions. All of the staff in the emergency department, including reception staff, are included in the training and the process outlined by the protocol.

Confirmed cases of abuse have not increased significantly since the introduction of the protocol, however significant improvements occurred in the assessment, treatment and referral of identified cases. The use of the homicide risk assessment, safety planning and referral to the police and other services increased from almost nil to 40 - 50% of cases. (Elvidge 1997) (Injury Prevention Research Centre 1996)

Note

An interesting technique of ensuring compliance with screening protocol was trialed in an American urban emergency department. In this service all nurses were audited quarterly to assess, among other things, their screening compliance. Those who failed to regularly achieve more than 90% screening compliance were subject to formal disciplinary proceedings. This was a four tiered hospital approved process including a verbal warning and written warnings. The fourth tier was termination of

employment. All nurses modified their screening behaviour by the third tier, thereby avoiding loosing their jobs. (Larkin, Rolniak et al. 2000)

Conclusion

This chapter has examined issues related to the response of physical health services to domestic violence. It is interesting that even at Middlemore Hospital - were a screening protocol exists - and in GP surgeries where training has occurred, that women are only being asked about domestic violence if it is suspected, not routinely screened. Therefore, rates of identification are not increasing. This suggests that the most effective services would be those that routinely screen for domestic violence and have procedures in place to usefully respond to disclosures of abuse.

Women want doctors to ask them questions about the abuse they are experiencing. This indicates that doctors and/or other health professionals have a potentially important role to play in helping women gain information and support.

Health professionals need to understand that women may not respond to their offers of help or intervention immediately or at all, as each woman will understand her personal circumstances and what it is safe and possible for her to do. This doesn't mean, however, that nothing should be done. If a health professional suspects abuse, it is useful if the power and control model is explained to women, to enable them to identify what is happening to them. Options for intervention or assistance should also be outlined so that women understand that there are services for them to access when they want to. (Jefferson and Elvidge 1996) Helping a woman, by acknowledging that what is happening to her is domestic violence, informing her about options and helping her develop safety plans, will contribute to her sense of wellbeing and enable her to take action when she feels ready.

There are a range of reasons that doctors and other physical health professionals are not currently addressing domestic violence. Many people do not see it as a health issue, believing that it belongs in the realm of social workers or the social services. Some doctors are not identifying abuse primarily because they are not asking about it. These people are just treating symptoms. Still others are suspecting abuse but feel unprepared to address the issues, either because they don't know enough about it or don't want to open up something that is difficult and messy. For others it could be because

they don't want to become further involved in the problem - either because they are uncomfortable with the issues or because they feel it takes up too much time. Other reasons doctors don't become involved may include a lack of empathy, poor practice, inexperience and lack of training. Many of these things could be addressed by ongoing in-service training about domestic violence.

The issues that have been identified for physical health services are also very relevant to the mental health services and much can be learnt from the studies and pilot programmes that are already in place.

Method Chapter

This is a qualitative study using phenomenology as the philosophical structure for the research. The research is based in a feminist analysis of the issues being investigated.

Method

Qualitative Research

In the available literature there is very little documentation of women describing their experience of 'going crazy' from domestic violence. There is, however, a significant body of primarily quantitative research documenting the effects of domestic violence on women's mental health, the number of women using mental health services who have experienced domestic violence and general information about domestic violence and, separately, mental illness.

This study has collected women's stories about their experiences of mental illness and domestic violence and has studied these to extrapolate themes about the relationship between these two issues. These themes are supported by the information obtained in the literature review.

This research allows women to describe their experience in their own words, adding depth, richness and authenticity to the quantitative research previously reported.

Phenomenology

In the context of this research, phenomenology allows an investigation of women's lives that gives primacy and credence to the themes and messages inherent in their stories. This is particularly important for women who have been marginalised and silenced by a diagnosis of mental illness - but is equally relevant to render visible all women's experience.

For this reason, phenomenology was chosen as the research paradigm, as it focuses on the experienced meanings and perspectives of the subject's world. It attempts to understand both the diversity and the essential meanings of their experiences and to reveal the underlying structure of this lived meaning. It does not describe situations through the focus/lens of scientific objectivity or theory. Phenomenology

assumes that scientific abstraction is a reduction of lived everyday experience and that the lived experience has primacy. *"The geographers map is thus an abstraction of the countryside where we first learned what a forest, a mountain, or a river was.*" (Kvale 1996)

When phenomenology is used as a method it is expected that the research will be asking questions about a life experience and will use a small sample, in-depth interviews, a close relationship between the researcher and the participants, analysis that involves engagement and reflection on and with the data and an interpretation that deals with the way people exist in their worlds. (Niven 2000)

Feminist research

This research privileges the experiences of women. It makes gender a basis of understanding the issue that is being researched. For too many years men's experiences and reactions have been generalised to women, denying women their uniqueness and hiding the reality of women's lives and needs. The research is designed to begin a process of engaging mental health services in a revision of their current response towards women who experience domestic violence and interact with mental health services.

In order to achieve these objectives the research must have an agenda of change. Research that is purely for the benefit of the researchers and not of the research subject is perceived, by feminist researchers, as exploitative. (Clifford-Walton 1998). Goodman et al, cited in (Martin, Morris et al. 1998) make the point that the problem of violence cannot be understood or changed by focusing only on the individual, but must address changing the social and cultural institutions that have fostered the violent behaviour.

Feminist researchers *"see knowledge as being historically, culturally and politically situated and being socially constructed as each person filters what they see and experience through their own previous experiences."* (Clifford-Walton 1998) Page 35. They reject the idea that research is value free and that there can be one truth or one interpretation of results/reality. Consequently, they believe that the way knowledge is interpreted is dependant upon the researcher's subjective interpretation, which in turn is based on her own values, ethnicity, education, age, class etc.

Researcher's perspective

The researcher is a Pakeha woman who has worked with women as a health promoter for sixteen years, including in domestic violence and mental health services. She has a feminist analysis of situations and takes a strong stand on issues of equity and inequality caused by socio-economic status, ethnicity, sexual orientation and religion. She believes that there is a relationship between abuse, the exhibiting of symptoms that can be interpreted/diagnosed as mental illness and a subsequent diagnosis of mental illness.

She has worked with many different women including women who have been in abusive relationships, women who are poor, are refugees or who have a physical or psychiatric disability. During this time she has talked to a number of women who have told her that their abusive partner has "driven them mad". A number of these women have been users of mental health services. Rarely did they ever find someone in the services who acknowledged their abuse and the causal relationship the women believe exists with their subsequent mental illness.

Treaty of Waitangi Issues

This research is being supported and overseen by the women at Tu Wahine, a kaupapa Maori organisation that works with women who have experienced domestic violence. Maori and non-Maori were invited to participate in the research. Maori have the right to participate in research and enjoy the benefits which may result from it. If research samples include only Pakeha, then the only group to benefit will be Pakeha. If Maori are not included in research samples the findings will not be generalisable to the New Zealand population.

It is the responsibility of the researcher to ensure that Maori participants are protected from any negative impacts in the process of being involved in the research and having the results of the research made available to the public. The supervision of Tu Wahine will ensure that negative outcomes are minimised.

Recruiting of participants

Advertisements were placed on notice boards in mental health outpatient clinics, mental health NGO services and with mental health service community support workers. Information was also distributed

among the researcher's networks in mental health and domestic violence services. The researcher approached the professionals directly via her professional networks.

Not all mental health services felt able to support this research. Some felt that the woman they worked with would be upset by reading the advertisement, or that harm would be caused to them by participating in the interviews. The researcher felt that this demonstrated a lack of understanding of women's rights and abilities to make choices about what they will and will not participate in. She chose, however, not to pursue this with those organisations, but to work with the people who were interested in the research.

Recruiting difficulties

It was very difficult to make contact with women who had not experienced abuse of some form as children. For example, one woman who identified herself as someone who had no previous history of abuse told the researcher, during the course of the interview, that *Dad never bit me, but he'd use intimidation, like threaten to hit me and with the power of his voice, I knew that if he was going to hit me, he'd just about kill me. Mum was basically like a zombie — she was... on heavy drugs all the time, in and out of mental institutions..."* (PI) This woman was excluded from the study because she was unable to give a coherent timeframe/line for the events that had occurred in her life.

Sampling

The participant sampling was purposive - focused and opportunistic. The researcher was looking for people who she felt would have expertise and experience that was pertinent to the research. All women who had experienced abuse were self selected however - many of them rang directly after having seen the advertisements – others identified themselves when the researcher was talking about what she was doing. A few were given invitations to participate by their friends or support workers.

Safety of participants

Some of the women who were interviewed had never had counselling for the abuse that they had experienced. Others may have had some, but had not worked specifically with people skilled in domestic violence counselling. In order to mitigate the potential harm caused by asking women to discuss abuse issues the researcher organised two Pakeha women counsellors, both experienced in working with women who have been abused and both ACC registered, who were prepared to work

with women who have experienced mental illness. None of the participants chose to avail themselves of this service. Many of them said that taking part in the interview and talking about domestic violence had been a positive experience, because of being listened to and believed. For many of them it was the first time they had been offered an opportunity to talk about their experiences. The women received, and had explained to them, the power and control wheel and many of them requested and received information about domestic violence services.

For Maori women, Tu Wahine, an organisation skilled in issues of domestic violence and mental illness were available to work with women. Participants were able to access ACC for their counselling. This service was not used as the only Maori woman who volunteered to be interviewed did not want to avail herself of this service.

If the researcher had concerns about the effect of the research on a participant she contacted them a few days later, to check if they subsequently wanted more support or help. None of the women felt they needed this - but were happy to be contacted.

Interview structure and procedures

The purpose of the interviews was to obtain an in depth understanding of people's experiences relating to the topic being investigated. Therefore an interview schedule was used, as the order of responses was not crucial to the research. The schedules were developed in consultation with colleagues interested in the research, some of whom were women with personal experience of domestic violence. Different schedules were used for the key informant interviews and for the women who had experienced abuse. The interviews were supplemented by observation and field notes.

Once women identified themselves as interested in participating, the researcher arranged with them where they felt most comfortable to meet. For most of the women this meant a setting outside of their homes, primarily for the safety of the researcher. Two women, whose abusive partners lived in other cities, were interviewed in their homes.

Each person who was interested in being involved was given an information sheet and when they decided to participate, a consent form - which was signed by the participant and the researcher.

Interviews were conducted in as informal and friendly way as possible, with women understanding that the tape could be turned off at any time. Two women asked for the tape to be stopped while they related a particular incident and then returned to taping again. In some interviews the researcher found it very difficult to remain neutral as the information being offered was very distressing.

The researcher reviewed the interview schedule after each interview to decide if there were areas of questioning that need to be altered, added or excluded, to refine the process. Data improved as the number of people talked to increased and the interview schedule was refined. The basic questions, however, remained much the same. Some of the women phoned after the initial interview to offer further information that they felt was pertinent. Some were contacted a second time to clarify issues that arose when reading the transcripts.

A number of the interviewed women met together with the researcher to discuss the themes that had been extrapolated, and to make comments on these, before the themes were finalised.

The interviews with the health and other professionals were designed to:

• elicit a professional understanding/opinion about the relationship between the abuse a woman has suffered in a domestic adult relationship and a subsequent diagnosis of mental illness

• explore what the participants think needs to happen to enable mental health services to respond to any apparent relationship between domestic abuse and mental illness.

The interviews with the women who had experienced domestic violence were designed to:

• Elicit their understanding of the relationship between the abuse they experienced and their subsequent mental unwellness - or feelings of 'going crazy'.

• explore what they think would have been a useful professional response to their situation.

The aim of the interviews was to test the theory that there is an un-dealt with relationship between domestic violence and mental illness and to broaden and inform current knowledge.

Responses were recorded by audio tape.

Pre – requisites

Pre - requisites for people to be involved in the study were:

• women who had experience of domestic violence.
• women who have, or have had, a diagnosed mental illness and have been abused as adults by a male partner.
• women who self identify as having experienced psychological/emotional consequences of abuse while in a relationship with a male partner.

For a professional to be involved in the study they must have identified an analysis of domestic violence and/or mental illness that did not focus causal blame on the person experiencing the abuse/illness and have some understanding of the concept of a social/cultural causation of mental illness. Many of them also had a feminist understanding of women's issues and practical experience working with women.

Excluded people

In order to eliminate some potential areas of confounding (issues that confuse the results) the researcher had initially planned to exclude the following women from the study.
Women who had been:
• abused as children - physically or sexually, within the family.
• abused by a stranger, i.e. a person they did not have a relationship with
• abused by a family member who was not their partner.
• Women who had a history of diagnosed or suspected mental illness prior to being abused by their partner.
• Women who can not communicate in English.

The definition of abuse did not include having witnessed abuse in their family of origin - only that which had actually occurred.

However, it soon became obvious that many of the women who wanted to be interviewed about the abuse that they had experienced with a male partner had also been abused in some way as children. This was despite the researcher very clearly stating in the information that the research was not about childhood abuse – and reiterating this during the initial conversation with a participant. The researcher decided, because of the women's desire to tell their stories, to continue the interviews with these women and to incorporate them, as an identified grouping, into the research.

The women who were excluded from the research were therefore:

• Women who had a history of diagnosed or suspected mental illness prior to being abused by their partner. One woman fitted this criteria.

• Women who can not communicate in English. No women were in this category.

• Women who had been so traumatised by their childhood abuse that they were unable to delineate between abuse experienced as a child and that experienced as an adult. Three women fitted this criteria.

The information about childhood abuse was obtained verbally from the women volunteering to be interviewed, not from medical or other records.

Excluded from the group of health and related professionals were people who the researcher believed would have a vested interest in this research not occurring. This included abusive men and members of some fundamentalist religious groups, other groups who believe that women should be subservient and submissive and groups or individuals that believe in power and control and physical discipline.

Numbers and characteristics of respondents

Interviews with professionals working in a range of fields related to domestic violence

Eight women were interviewed for this part of the research. Of these, six were interviewed individually and two chose to be interviewed together. The women were employed as: a case worker at the Domestic Violence Centre in Auckland; a health promoter specialising in domestic violence; two mental health social workers – one was the senior social worker in the service; an occupational therapist with a mental health team; a clinical psychologist in a community mental health service; a volunteer at the South Auckland Family Violence Prevention Network and a community mental health worker. Three of these women had experienced some domestic violence, not necessarily physical abuse, in one of their relationships, but chose to speak from a professional rather than a personal position.

Three other people were spoken to less formally. These people were all spoken to individually. Two of these were men. One is a psychologist who teaches at Auckland University, the other is a counselor

with a helping agency in Hamilton who specialises in working with men who have been sexually abused as children. The woman who was spoken to is a public health nurse who has a strong interest in domestic violence issues. One of these people has had personal experience of domestic violence.

Nine women were interviewed for a previous research paper about this same issue. (Hager 2000) Their responses have been included in this thesis as the methodology was the same. Of these, six were individual interviews and one consisted of three women who chose to be interviewed together. The women were employed as: district court staff; the police domestic violence coordinator - Auckland central; a psychologist in a gynecological ward and as a consultant to the North Shore Woman's refuge; a refuge social worker from Merivale refuge; a mental health community support worker and a psychologist who also works as a counselor for the family courts.

Women with a history of childhood abuse

Six women were interviewed who, as well as experiencing domestic violence as adults, had been abused in childhood. Of these, two had experienced physical abuse, one physical and emotional abuse, and three sexual, emotional and physical abuse, all from within the family. One of the women was also raped by a stranger when she was 14 years old. One of the women comes from a family with a mentally ill mother, who she has a protection order against. The women range in age from 63 to early 20's. They all have children. Two of the women currently work in mental health services and have not used the services themselves. The other four work part-time in a paid or voluntary capacity and use, or have used, mental health services. These women are all pakeha.

Women with no history of childhood abuse

Four women were interviewed who had no history of abuse before meeting an abusive partner. These women range in age between late 40's and mid 20's. All four of them have children. One works full time in a mental health service, two work part time and one is currently not working. One woman has used mental health services. One has had medication prescribed by a GP and describes herself as having been anxious before she met her abusive partner. These women are all pakeha.

Data analysis

Data gained in the interviews was analysed by the phenomenological method of meaning condensation. This involves:

• Identifying key essences or themes and ideas related to the research topic and from these creating 'natural meaning units'.

• Interrogating these meaning units in terms of the specific purpose of the study.

• Further condensing the material that has been generated into descriptive statements that explicate the essential meanings and structures of the original
received information.

• Looking for what is not being said, as well as what is.

Giorgi (1975) cited in (Kvale 1996)

The repeated reading of transcripts and checking of data items and themes against others was used as a check on consistency. By doing this, distortions, inaccuracies and misinterpretations were less likely to occur. (Cutcliffe and McKenna 1999)

Validation of results

Triangulation of information between women's experiences of abuse and subsequent mental illness or feelings of being 'crazy', the relevant literature and interviews with people from services that interact with these women was undertaken in order to develop a broad picture of the issue being investigated - the relationship between mental illness and domestic violence - and to enhance validation of the results. Appleton, (1995); Redfern, Norman (1994); Begley, (1996); cited in (Cutcliffe and McKenna 1999) This involved studying both up and down - i.e., talking to professionals as well as the women who have experienced the abuse, in order to understand their experience and the relationships inherent in the experience from a range of perspectives and paradigms.

Results

Introduction

> *Women are seen as victims of violence - there are thousands of us who have learnt to be survivors you know.* (S 2)

The results of the study are reported in six parts. These are: Key informant interviews with health and other professionals; interviews with women who have experienced childhood abuse and adult domestic violence; interviews with women who have only experienced adult domestic violence; the reasons, extrapolated from the interviews, why women don't leave abusive relationships; a comment about the relationship between childhood abuse and domestic violence; and the themes that emerge from the interviews.

The key informants identified a relationship between mental illness and domestic violence. They felt that abused women lost faith in their own perceptions of reality and consequently felt that they were 'going crazy'. This state can be diagnosed as mental illness but is, in fact, a reasonable response to circumstances - not a pathological state. They identified that these women required time, space and safety to have confidence in themselves again. They suggested that mental health services are not currently identifying these women and that they, and other services that women access for help, are often perpetuating abusive behaviour.

Both women who had been abused as children and those only abused as adults identified a relationship between mental illness and domestic violence. For some of them this was because they had used mental health services. All of the women wanted to be asked specific questions about their circumstances and to be given language to describe what had been happening to them. They also

wanted to be heard and believed when they told people what was going on. Women who had only been abused as adults were very clear that their feelings of being crazy were a result of the situations that they were/had been living in, not of mental illness.

The responses to the interviews are reported under the questions that were asked. Where a number of respondents gave similar answers, these have been summarised and represented by a quote from one respondent that contains the essence of what has been said.

Responses from the interviews carried out last year are referenced as (Hager 2000).

Key informant interviews with health and related professionals

Professionals working in fields related to domestic violence or mental illness were interviewed. In answer to the questions that were asked, these people replied:

What is domestic violence?

Allowing for differences in phrasing, all of the respondents defined domestic violence as physical, sexual, emotional and psychological abuse "... *emotional violence...physical and the more subtle, like control...*" (J3), occurring in a family setting and all agreed that they were talking about men abusing woman who were their sexual partners "*...It's ... male partner abuse..." (J2).* The power and control model of domestic violence was understood by the respondents *"...the power and control wheel...*" (J2), with different people highlighting different aspects of abuse including physical, mental, sexual, emotional, financial and verbal, *"...emotional cruelty, managing finances in a way that's cruel, using the children to control or punish or frighten, ... isolating her, sexual violence, ... undermining confidence steadily over the years..."* (Rl)

Also mentioned were more specific issues such as *"people living in places where they don't have choices" and* their *"emotions and thoughts are controlled"* (C2) and women not having adequate food, clothing and bedding. *"Terrible isolation"* (J2) was mentioned and also discussion about the *"colonising process of abuse...to make someone think that everything about them is wrong"* (Jl).

All of the respondents insisted that physical abuse was only part of the problem and that the other forms of abuse were at least, if not more, destructive.

> *I believe that there doesn't always have to be physical abuse — but when there's physical abuse there's always psychological abuse and that psychological abuse is probably more prevalent than physical (abuse) ... too often people have got a tendency to believe that family violence is only about the black eyes and broken bones and its not, it's more about a breaking of the spirit.* (S2)

What is mental illness?

While the interviewer and the respondents had a shared understanding of the definition of domestic violence, with mental illness there was more divergence of understanding and explanation, as some people have a professional analysis and others have a lay person's perspective. Some of the respondents didn't feel that they had enough information to give a definition. These people talked about the range of behaviours that could be mental illness, from occasional depression to chronic psychosis and tended to use the language of mental illness diagnosis, e.g. schizophrenia, bi-polar disorder, depression and anxiety disorder, rather than talking generically about what mental illness is and is not.

> *.../ know about illnesses like schizophrenia and people who are bipolar and apparently that's some kind of chemical reaction that can be medicated. I suppose I know that people can get depressed, I know there's all kind of mental illness, but some people manage it and live with it and for some people it's always a terrible torment...* (J2)

Those who felt more able to give an opinion spoke about a continuum of mental wellness and illness that we all moved up and down, a disorder related to peoples thoughts and feelings that can be caused by stress and life events and:

> …a *way of codifying human distress....it operates on a continuum, in that most of the experiences that we have as human beings go to extremes and some of these extremes are called mental illness.....It is made prettier by being called illness...rather than saying this is a result of how we torment our children and torment people that gives them levels of distress they can't cope with.... calling it*

an illness makes it seem more polite than social problems or torture or what ever else you 'd like to call it. (R 1)

Three of the respondents talked about the DSM IV, the diagnostic tool used by the mental health services. *,"The DSMIV is a very dominant method of assessing human beings within psychiatry"* (J4). One woman talked about what mental illness is not, i.e. it is not intellectual disability *"...that people who experience mental illness have a normal intellect and often start off life with the same range of opportunities as everyone else"* (C2)

What are the long term effects of domestic violence?

A wide range of behaviours were identified as being the behavioural manifestations of living in an abusive relationship. These can be grouped under the following descriptions. On-going fear, lack of volition, lack of motivation, " *inability to cope with everyday life"* (S2), diminished ability to cope with stress, being *"superwoman"* (Hager, 2000), vigilance, one participant described vigilance as being continually watchful, suspicious and afraid, including for the children (Hager, 2000), depression, worn down, shattered, disassociation and the blocking out of the worst things that have happened - having gaps in their lives, *"their reality checking becomes really poor" (J1)* and losing faith in one's own decision making ability.

...they've submitted to a point where they are powerless...under constant barrage from the defendant that they're the ones with the problem - they're mental anyway...

I think in chronic beatings, and predominantly being put down and abused physically, mentally, sexually, you name it, obviously it's going to impact on their wellbeing and I don't know how these women are functioning as well as they are. (Hager2000)

...the more information you've been getting all your life...of being told all the time that you're mentally ill and you're crazy, you're stupid, in the end you believe that you're crazy...once you think that, you will think "I deserve this cause I'm crazy - anyone would treat me like that if they had to live with someone who's crazy"...if you totally believe that you're crazy it's nearly impossible to get out of it...it affects the way you live your life. (Hager, 2000)

These women are described as being "*isolative, don't mix socially, anxious, are often guilty, they talk about feeling anxious and inadequate ... become protective of themselves... loss of esteem, anger..."* (J3)

One respondent talked about how women lose all sense of who they are and what is real and another about women developing "*a complete loss of hope for the future, or safety in the world, generalised terror or sometimes generalised inertia, with hopelessness"* (Rl). *"Post traumatic stress disorder"* (Jl) was also mentioned.

> *I think that women lose all their self esteem and their reality checking becomes really poor … because part of abuse is isolating people and giving them misinformation. They buy into a whole lot of stuff because they're so disempowered they believe anything and...1 think it does make you crazy.* (J2)

Being suicidal, using drugs and alcohol, *"taking pills like lollies, that's how she was coping, self medicating to get through it...made her more confused..."* (Hager 2000) having eating/body image disorders and long or short term cognitive impairment and verbally or physically abusing their children, having problems with hygiene and personal grooming and promiscuity were also observed behaviours of some abused women.

> *... people who abuse substances, who have problems with food, cigarettes, grooming, clothing, care of their environment as well as their own body, their own space - right through to all the self care things like choices they make around self abuse, promiscuity, taking risks around alcohol, drugs, all those sorts of things...* (C2)

An inability to organise even day to day necessities was frequently mentioned**.** This was described as:

> *... not being able to get out of bed, not being able to do the housework, not knowing where to start ... it can often get worse after you've left because before, you do it to stay safe, to try and manage his behaviour... and then when you leave there are massive processes to go through that you may never have been through before... this sort of keeps you going, but a few months later it's like - it's almost*

> *like emotional overload and all you want to do is go home and crawl... into bed and not get out.* (S2)

One respondent noted that the long term effect of domestic violence, for some women, can be the *"motivation to change, get out, rewrite their history" (P1)* Another said that for many women this behaviour was not a traumatic response to past abuse but "*a … realistic response to a current situation" (S1)* because some men never stop harassing and abusing their partners, even after they (the ex partners) have started other relationships.

In the literature there is evidence of a wide variety of ways of analysing behaviours such as these. (Koss, Goodman et al. 1994) (Campbell and Humphreys 1984; Herman 1992) Many of these attempt to cluster, label and explain the behaviours as syndromes - to attribute these behaviours to a pathology, so that the response to them is therapy.

Is this behaviour mental illness?

These behaviours, itemised above, were identified as being reasonable responses to the situations women were in. Some respondents, however, indicated that some women required extra help because they were no longer functioning even within these abnormal parameters. " ... *say for example someone's hearing voices, you might do some analysis on where that might have come from, but really today that's what we have to deal with... that's what's happening in the here and now..."* (C2)

Others felt that giving a diagnosis of mental illness was not appropriate:

> / *don't see that what I see as quite normal responses to living with violence should be pathologised. There are unpleasant and probably quite appropriate responses to violence...I'm inherently cautious about how women get labels stuck on them, because they respond in perfectly normal ways to certain things that the medical model may not otherwise know how to deal with.* (J3)

One respondent talked about her own situation and how she was supported and reassured by her doctor - compared to many other women she has met subsequently who were in similar situations but are now addicted to prescription drugs because their doctors just wrote prescriptions instead of affirming their

situations and the ways they were coping. *"I was depressed and I was panicking about my son*'s *well being - but I wouldn't say I was mentally ill. You know for a short period I might have had a problem, but with the right intervention I got through it.* (S2)

Is there a relationship between mental illness and domestic violence?

> *One woman was beaten up by her partner...she was locked up in the police station...the beating induced a psychotic episode...she can't really remember - it was horrible. She ended up in hospital on heaps of medication and she's been in the system ever since. She was 17-18 years old. She's now 36...she blames the beating for her mental illness and no psychiatrist will be able to tell her different...and I believe her.*
> *(Hager, 2000)*

The participants all identified a relationship between mental illness and domestic violence. This was not necessarily a directly causal relationship, but an understanding that the two things were linked in some ways.

> ...(for some women) *every abusive relationship is one cumulative stage further on to damaged mental health because if you don't have a view of your self as a worthy person who is treated respectfully, your mental health is always at risk. (Hager, 2000)*

> *It makes you crazy...you lose groundedness...lose all sense of who you are... I think because reality is denied to abused people so often...because (abusers) minimise the violence they're perpetuating, because they minimise everything they do, they are denying reality all the time so the person's reality is being denied.* (J2)

One of the respondents felt that domestic violence was only one stress in a woman's life that compounded other things that had happened to her. The others perceived a more direct relationship.

> *People try not to be who they are, feel what they feel…and I think this is crazy making.* (Jl)

Respondents talked about how domestic violence causes symptoms that are perceived as mental illness and how both physical and mental health services respond to this.

> *I think it's one way ... domestic violence produces symptoms of something called mental illness ... I think it's a problematic relationship because the symptoms get attention via mental health services but there's also all the stigma associated with seeing the woman as mad..... often in custody disputes this counts against the woman.* (Rl)

> / *think that some women suspected of mental illness aren't symptomatic of an illness, they're symptomatic of the environment they live in ... Too many women in particular have been labeled as mentally ill when their only problem is family violence — is low self-esteem and the depression associated with it because of their living environment and I think a lot of women, they present to their doctor or what ever and they're misdiagnosed, whether because it's in the too hard basket or that they don't want to open up this can of worms ... it's kind of like they don't know what to do ... what to say ... sometimes it's easier to give her a prescription for some pills and send her on her way. Sometimes all she needs is someone to listen to her and reassure her that she's not mad, it's the conditions that she's living under that are abnormal.* (S2)

A number of the respondents talked about the way women are driven crazy by having their sense of what is real constantly challenged and denied. This is compounded for women by not being able to name what is happening to them - either because they have no understanding/language for what is happening or they are not permitted to speak about it.

> ... a *lot of healing for ordinary women was helping them name their reality because they'd had it taken away from them ... when your reality is called something else it makes you crazy...* (Jl)

What could mental health services be doing to address issues of domestic violence?

The answers to this question are generally from a presumption, indicated by most of the respondents, that mental health services are not currently providing appropriate and constructive services to women who are experiencing domestic violence. Five people worked for mental health services, however only one woman felt that the mental health service that she worked for was aware of the issue and had staff who could work with a woman to identify and ameliorate her situation.

There were a range of suggestions as to how mental health services could work with abused women. These include: knowing *"how to recognise that it's (abuse) actively happening and intervene"* (C2); ensuring that women who enter their services are safe, or can develop safety plans, having equal access to both mental health and domestic violence expertise *"when you've got the 'duel diagnosis' you need the combining of two kinds of information..."* (J2); having specific services for these 'duel diagnosis' women, "*... I think there need to be specific programmes for them..."* (J2); *"exposure to a feminist perspective"* (J3) about domestic violence as an alternative to the medical model; *"screening every client - men and women"(Jl), as* abusers may also be using mental health services; following up any disclosure of abuse because both abusers and people being abused always minimise violence (Jl); *"referral to domestic violence agencies"* (Jl); " *...we do little bits in terms of lobbying..."* (Rl); enabling women to access multi levels of care. *"Women should be able to access multi levels of care, the best they often get is medication..."* (Rl)

> *There needs to be an awareness ... an open mind to what you're assessing and, if what you're assessing is a normal response to domestic violence, that you would respond differently than if what you're assessing is somebody who is ...psychotic.* (J3)

Screening was considered a minimum response. When the interviewer mentioned the research suggesting that mental health professionals don't ask women presenting at their service about domestic violence because it will upset them too much, and they will end up having to treat her for this distress, the response was:

> *... yeah, she's going to get upset, but she's also going to get upset when she talks to her lawyer getting an affidavit and she's got to read that affidavit to make sure it's the truth and all of a sudden it's like, she sees life with this man in front of her*

> *and it's in black and white and she realises how bad it really was - she's upset then. A lot of women minimise what happens to them, because if you really face the truth of it you wonder how you stay ... now women have told lawyers about the reality of their situation, women have gone into refuge and have talked to another woman who has no qualifications apart from the fact that she cares and women survive it without falling totally apart... and that's part of your healing ...these women don't fall apart all over the place and stay forever damaged....* (S2)

One respondent talked about what services shouldn't be doing - which is reinforcing an incorrect diagnosis of mental illness when the problem is ongoing domestic violence. "*... it's like all we were doing was reinforcing the mental illness diagnosis that was not relevant..."* (Rl)

Another respondent talked about how women need:

> ...a *specific intervention for women who... have got to a point where they are really having problems responding to what goes on around them - where they're not experiencing reality very well... a specific intervention that assists women to find their voices again...* (Jl)

> *The biggest thing is that violence is not ok and reassure her it's not her fault. But to do it in a non-threatening way, not threaten her with - well I'm really concerned, I think you need…, you're going to lose your kids - that's worse than shutting up and not saying anything, so it's learning to ... treat other people with respect, treat them as a person. (*S2)

How could these changes be made?

Responses to this question include: more resources - money and staff, staff training - *"staff who are trained in social, family, community type ways of thinking'* (C2); training specifically about the power and control dynamics of domestic violence; training about confidentiality and safety; *"joint ventures/partnerships between mental health and community agencies'* (Jl) to bring in expertise not found in mental health services; and *"...they need to be trained in how to ask the right questions and give the right answers..."* (S2) about domestic violence.

There was also concern expressed that, by moving into acknowledgement of domestic violence, mental health services didn't work to perpetuate the abuse.

> *It's a very difficult one to intervene in because people are in denial and if you close in, so they feel threatened and got at, then you're just another perpetrator controlling them - and if you close in too hard they've got nowhere to run, nowhere to hide so they'll go back to the abuser" (C2)* and " *The system has to watch that it doesn't become the abuser. In trying to be nurturing or caring you can end up being very paternalistic.* (C2).

Concern was expressed by a number of respondents that because there are relatively so few staff working in mental health services, for the number of clients that they see, that there is not enough time to do anything but the crisis work and the medication. *"Structurally, looking at the way mental health services are set up now,... to ask us to find ... resources and expertise to do that within our team, or even within mental health services and the CHE (hospital)... is ludicrous..."* (J3)

Women who have experienced childhood abuse and adult domestic violence.

The second series of results come from the interviews with woman who had experienced abuse in childhood as well as domestic violence as adults. Four of the six women interviewed in this group have used mental health services, the other two now work in mental health services. There were no discernible differences between their responses, as all of them have experience of the mental health milieu.

In response to the questions they were asked in the interview, this group of women replied:

What is domestic violence?

The answer to this question included: *"it's hurtful... it really does affect you and your family, it's punching or slapping or throwing you around..."* (Tl); there's tension and lead-ups, it's mental, physical, and emotional; *"Verbally first...mental abuse, criticism, manipulation then it lead to controlling, before physical abuse... being made to feel powerless."* (Bl); putting women down and

holding her prisoner, its "*an abuse of a power relationship*" (B2); *"l used to think it was just... physical contact, but now I realise it's more subtle than that, it's intimidation and other sorts of behaviour ... designed to get what the person that's using the violence wants ... a way of keeping things as they are."* (S1)

The women talked about financial abuse, about not being allowed to work or having to work all the time. Also about isolating someone, by changing cities or countries or making her work so hard that she never saw anyone and not being allowed to have people in the house.

During the course of the interviews a number of the women talked about adultery as part of the abusive behaviour.

There was a reasonably consistent understanding of domestic violence among the women. All of them identified it as being about power or control. They also identified emotional/psychological abuse as being more destructive than physical abuse.

What is mental illness?

There were a range of answers to this question reflecting both the personal experience of the respondents and also their learnt knowledge. Responses based on personal experience included that mental illness is hallucinations, delusions and dreams brought on by trauma, anxiety, *"feeling fuzzy in my head'* (Sl) and not something that's black and white.

Another way of defining mental illness was to name illness such as schizophrenia. Mental illness was understood to be caused by drug abuse, alcohol, trauma and accident and to be as a result of psychosocial causes, genetic vulnerability, lack of chemicals in the brain, family circumstances and birth trauma.

> *It's an incapacity... you can define it as three things - biological, physiological or brought on by abuse, which in the end I don't really think is a mental illness but it's classified as that.* (Bl).

Have you said or done things that you think are signs of mental illness?

This question elicited many, varied, responses. These can be grouped under the following descriptions: Being suicidal, abusing substances, being depressed, being anxious all the time, fear, low self esteem, feeling like I'm going crazy, unable to initiate anything with confidence. *"I'm told I used to obsessively clean the house...! didn't realise I was doing it... I was over fastidious with the children, smothered them I'm told now."* (Bl)

> *...I've been really anxious and I think the things I've been anxious about are real, so I get confused about that.* (S 1)

> (I) *disconnect/detach from what is going on - I can't often remember because I learnt to cope - when I had time off to think about what happened.. .you cope until your brain and your body say enough.* (Al)

Two women spoke about delusions and hallucinations - one of whom was critically physically ill at the time the hallucinations occurred. Two women had been given a diagnosis of schizophrenia; another has had two or three diagnoses. "... *they told me I was schizophrenic..."* (Bl)

One woman had planned how to kill her husband and had actually attempted it. She became frightened and phoned emergency services. Another woman fantasised about burning down her house.

> *I was having these thoughts about how I'd like to burn down the house ... before I thought I'd like to bum down the house when the children were out of it, but now I was thinking of doing it even if the children were in it...* (B2)

Have you said or done things that other people said were signs of mental illness?

These women had been told that they were mad by a number of people. Most of the women had partners/husbands who told them they were mad or crazy, some were told this by their mothers, others by their doctors or by the mental health services.

> *My husband did...went to the doctor - he put me on anti depressants, I didn't tell him what my home life was like.* (Bl)

> *If someone said to me you have schizophrenia - which they have - I believe them because my text books say...* (Tl)

Two of the women were taken to psychiatric hospitals by their husbands.

> *... We got to a point where I knew, one way we was going home and be didn't take that turn off and I thought "oh my god, he's not going to go home, I can't believe he's gonna drive me to this mental hospital", and he did. He drove me, not a word he said all the way there. We get there and he signs in this form and he walks out the door and I sat there and I thought, "well, this must be where I'm meant to be".* (Al)

B2 says her husband tried to have her committed, but it didn't work.

Do you think what you were experiencing was mental illness?

> *One of the things that I have trouble with is that I want to accept that yes, I have a mental illness, but I think its justified. I mean it was a normal reaction to a really horrible situation.* (Sl)

Three women said that they did not think what they were experiencing was mental illness. "*No I was just confused and angry, but sometimes it would be so bad your head would want to burst"* (Cl)

One woman didn't answer the question and one said "*Yes, I probably thought they were true, (the things her husband was saying about her) . I thought I was in denial that I had a mental illness. ...I thought yeah yeah, you 're right but shut up."* (B2)

What caused you to feel this way?

Most of the issues raised by this question were common between two or more women. These are: A build up of stresses, a whole lot of emotionally difficult things happening at once "A *whole lot of events at one time"* (Tl), being told I was crazy, working to support a business plus all the child care " *I was working myself to death ... I looked after the children and did all the cleaning in the restaurant and all the food preparation during the day, plus looking after the children plus waitressing at night and when*

I look back I was getting not very much sleep ..." (B2.). One woman also had a child with a disability to care for while trying to run a business and care for her other children. Others talked not having anywhere to go, " *there was just no escape for me... there was just no way out"* (B2), the husband/partners inconsistent behaviour and no time to process what was going on. "I *couldn't cope* ... *it was like I'm going crazy, I can't cope... because it was going on and on and on. I was trying to do the right thing* ..." (Al). Youth and/or inexperience were also cited as reasons. "*I think it's a case of trying to survive beyond myself at such a young age"* (Tl). One woman said that her children told her that her husband was sexually abusing them but she didn't believe them. Other comments included:

> /... *was living through an untenable life situation without any support* (Sl)

> ...*because he would tell me get out.. .I'll give you a hundred dollars, get on the bus and get back to where you belong, and halfway there he'd change his mind and come and get me...* (Bl)

What kinds of abuse did you experience?

There is an extensive list of abusive behaviours that these women have experienced.

• Threats to kill

• Intimidation. *"Intimidation, with property, not weapons*" (Tl) " *What goes on in these four walls stays in them.. .if I ever hear anything coming back you're for it"* (Bl)

• Hitting, punching, beating "... *in front of his mother he nearly killed me and I ended up with massive bruises over my face, my neck, legs, around my stomach..."* (Cl)

• Fear *"fear was a prevailing emotion"* (B2)

• Gun ownership

• Emotional putdowns *"He'd turn to me and say, "you're fat, no other man will want you", putting me down and after a long time of negative thought - you're no good, you're lazy — then you tend to feel that it's all I can do, I am this, and sort of become a non-person... going through the motions, have no feelings, think this is going to be my lot..."* (Cl)

• Saying she's crazy

• Control. How to walk, how to talk, what clothes to wear, how to behave, what to *eat.. "when he wanted me to walk in a certain way...and be didn't like it if I had a certain look on my face"* (Sl) *"It never was an outburst, a loss of control. It was all very controlled, the whole lot, everything premeditated, very controlled."* (B2)

• Isolation. No-one allowed in the house, "*I was being cut off from everybody, like an emotional prisoner in my own home"* (Cl), working too much to see people, moving town or country, coming home at lunch time to check up on her. *"limiting me to the house,... by no transport, basically I didn't know how it was done, I just conformed..."* (Tl)

• Jealousy

• Using objects as weapons and to rape - *"shoved wood up my bottom"* (Bl)

• Denied access to children

• Using the children.

> *He actually used the children a lot because we actually went back to England for a working holiday for five years, to save up some money. I actually liked it. I got to see all my family again and the kids got settled into schools. They had then own friends and then when the five years was up I decided, no way I'm going to go back, I like it here and I can remember the night that I told him and I thought I'll tell him when he's eating his dinner 'cos he's sitting down and be won't jump at me or throw something. And I couldn't believe how calm he was and he said, oh that's alright... and then he said, but I'm taking the boys with me if they want to come... and the oldest one said, no, I'm staying at home, I'm staying here with Mum, I don't wanna go back there. And he threw that at me and he said, see what you've done? And I said, what? And he said, you've split the family.* (Al)

• Enrolling children into abusing their mother

• Told to leave then brought back

• Told to come back then having entry denied

• Thought he would kill me

• Bl's husband tried to poison her while she was in bed recovering from surgery to her elbow and knee, both caused by injuries he'd given her. She didn't detect the poisoning, her friend did and the hospital confirmed their fears. He was poisoning her with derris dust, but no-one went to the police.

• Lying

• Adultery

Sexual abuse was referred to in a number of ways. Some woman were raped, either with or without being forced to consume large amounts of alcohol, others didn't feel they could say no when their partners wanted sex. Some women experienced sexual contact that damaged. One woman had to cut short her honeymoon because she was bleeding so much she had to have corrective surgery that

prevented her ever having her own children (she adopted children). This woman also got recurrent Chlamydia, which was not identified by her doctor.

> *All the time trying to ply me with double gins, sometimes triple, and I wasn't a drinker... and be would try and almost rip my clothes off me.* (B 1)

> *That (sexual abuse) was pretty much a constant through out the whole time. I didn't know that...but in the end that became so bad I thought he was going to kill me.. .he kept wanting to have sex with me.. .he was doing it all night. He was forcing alcohol down me and then (the) sexual thing was going on and I didn't want to be having sex with him...* (B2)

> *When he got drunk, and I hated that too, but he felt that I couldn't say no. And that was really horrible because he wasn't considerate at all over me, how I felt or anything. It was just like, I want to get satisfied, that's it. And of course, when they're drunk, the more they drink, it just goes on longer and longer and more and more painful until they crash in the end and they don't get satisfied ... So yeah, I used to hate when he 'd come home because I didn't know if was he was gonna yell, moan about something or how much he'd had to drink because all those things were dependent on his mood.* (Al)

In answer to the question about abuse one woman answered:

> *You name it just about. We were in a relationship for 18 years. Most of the time it was kind of secret. I had to support myself, he didn't support me, we had two children, had a business together. I got no money from him, no emotional support, and I worked to support the family through the whole relationship and at the same time he was pretty well doing what he liked... he never told me that I did anything well... there were a few times that he hit me. A couple of times I went to doctors and things and talked about how I was feeling, you know, I thought I was going crazy...* (B2)

Did you tell anyone about it?

Most of the women didn't talk to anyone about the abuse they were experiencing – or if they did, only tried once or twice. Some of them were asked by doctors or others about what was going on, but denied that anything was wrong. "No, *no, no, I told* him" (Bl)

> *No I didn't tell anyone - "I think a couple of doctors may have asked me on different occasions. Oh actually once I did report it. When I was pregnant... with my first baby he beat me up...and I went straight to the doctor. I was quite hysterical about it for some reason, because he'd beaten me up plenty of times before and after, but that time I got quite hysterical about it so I went to the doctor and the doctor prescribed a sedative.* (B2)

Two women eventually told their mothers, some told their doctors. Two women were abused in front of their husband's friends and presumed therefore that they knew what was going on. One woman confided in a judge who was committing her to Kingseat psychiatric hospital - it did not result in having her released.

One woman ended up at Auckland hospital - she threatened to jump off the harbour bridge if her husband didn't take her to the hospital and she told the social workers about the sexual abuse. They asked her husband to verbally agree to a contract not to do it again until they saw him again. Then they had family therapy - where she was unable to talk about the abuse. She thinks her husband wanted her put in a psychiatric hospital while he ran away with the money from their business - which he did eventually do.

One reason, given by a number of women, for not talking about the abuse they were experiencing, was that they didn't recognise it themselves. Because they had no language for what was happening to them they were unable to name/describe it.

> *... like, if my doctor says to me "is your husband abusive?", I'd say no, no, no. It's not because I'm hiding something, it's because I don't think he is. I just think I'm not good enough and he gets frustrated because he likes perfection.* (B2)

Another woman said she couldn't identify her husband's behaviour as abuse because he didn't ever hit her.

Have you had contact with mental health services - have you told them about the abuse?

As mentioned at the beginning of this section, four of the six women interviewed in this group have used mental health services, the other two now work in mental health.

The four who have used mental health services responded. One woman told her psychiatrist who " *was really shocked... she set up some safety measures"* (Sl). Since this time, however, Sl feels that she has been put in some unsafe situations by psychiatrists who have expected her to talk about abuse in front of her abusive partner. Another said that she had given some information about her abuse to her mental health service workers, but didn't feel that she was ready to talk about it.

> *Well I think they're looking for more information and I haven't been ready to give that information out... I'm strung out enough at the moment with the fact I've got schizophrenia.* (Tl)

Of the other two women, one said that she didn't say anything about abuse. *"...They asked me how I was and I said I'm fine and they said do you need any help at all and I said no, I was just tired and I've caught up on my sleep, I just wanna go home..."* (Al). The other one also said that she hadn't told anyone about the abuse, but then contradicted herself and indicated that some of the staff did know about what was going on. This woman was in psychiatric hospitals a number of times, for varying periods, so these responses will all be from different times and situations.

> *I thought I was sane ... they told me I was bi-polar, then they told me I was schizophrenic and I was having all these drugs and I was hallucinating, I was hearing voices and ... the psychiatrist said you shouldn't be on all these drugs but you have to be on something ...my husband would ring me up and say "when you're well I'll take you back". Then he'd ring back and say "I won't have you back". The nurses cottoned on because they used to listen on the intercom ... I'd get hysterical, I was pulling out all my hair. I was so angry and I couldn't get this anger out.* (B 1)

> *I got punished because I wanted to take my anger out on me or someone else.. .not discharging you till you get the anger out.* (Bl)

When she was asked if the service had responded in a helpful way once they knew about the abuse she responded: *"Yes, but they wouldn't stop giving me the drugs".* (Bl)

The two women who now work in mental health services had not specifically told mental health services about the abuse they experienced, however, one *"told my boss and he was supportive"* (Cl) and the other was given family therapy, via a physical illness hospital social work service, *"...we were referred to a group of people, an enormous number of people, for counselling and we went in there and talked and they all talked at us ... because this wasn't abuse that was happening, this was marital problems* ..." (B2)

What should happen?

When the respondents were asked what they would have liked to have happened, and what would have helped them, there were a wide range of answers. Most of the women, when asked, said that they would have wanted to be asked about abuse. Two volunteered this information without being asked.

> *They're trained professionals, they should have known. ... I wanted them to say it to me, instead of me having to admit that you're (I'm) a failure.* (B 1)

> *I think I should be asked, but I think coming out with the victim support and other services, if there are any other services ... straight away. With me I was lost, I was lost to it twice.* (Tl)

When asked specifically about what should happen during the initial assessment from mental health services and if she would have liked to have been asked about abuse, this woman replied:

> *I think I would have responded quite well. I think I would have opened up a little bit more, just a bit more, because I didn't open up at the hospital... in hindsight I think I would have liked someone to have said that to me, to bring me out of my shell.* (Tl)

Another woman felt that mental health services had their own agenda, that didn't include hearing what she was trying to tell them about the abuse that she was experiencing. She wanted to *"know what their agenda was ...they obviously had a plan and I didn't and I can't see what use the plan is if I don't know.*

Is it set up to make me feel safe?" (Sl) She also talked about wanting a place where she could feel heard, not intimidated.

> *...it had just begun to occur to me that these doctors were actually really creepy and they weren't hearing what I was saying and they didn't seem to notice that I was being abused while they were watching it, and I found that really disturbing.* (Sl)

> *Their reactions made me feel crazy... it's always me doing something wrong.* (Sl)

One respondent just wanted a book that she could read by herself, that explained what she was going through.

> *Nobody believed me ... when I was saying what I was coping with. They didn't understand so I know a book I could read by myself, and just knowing it wasn't me, would have helped."* (Al) *"...what I was going through I felt nobody would believe me if I spoke about it, and if I did they would say "well you 're lucky he don't beat you up, because he could do that... and that's much worse"... but it isn't, because people can see that you're hit and they'll ask you and eventually you'll say what happened, but it doesn't happen if it's mental.* (Al)

A number of the women thought that abuse should be named by the people that woman go to for help and that the available services be identified.

> *I would have liked it* (to have had domestic violence identified). *I don't think I knew that the verbal side of it was domestic violence ...I don't think most people realise that emotional abuse is just as bad as physical ... knowing there were places to turn to, knowing there was someone who would understand what you're going through, people to talk to who would help you identify what it was that was happening for me...(Cl)*

What would need to happen for these things to occur? - What do mental health services need to know about domestic violence?

Not all of the women answered this question. Those who did had a number of suggestions, most of which relate to the naming of abuse and the dissemination of information about domestic violence.

> *I think they need to recognise abusive behaviour ...to name it and to recognise that it's not ok. I don't see that most of them have begun to do that. So that does leave me with the crazy feeling, when I say it, it leaves me with a feeling like I'm out of control, because if I do have to contact any of them again it feels like it's me that's going to be labeled. Because that's what keeps happening.* (S 1)

> *...they need to be very clear themselves about those issues of power and control. I think that's fundamental... because the victims can't name it themselves. I've never come across someone who says "oh well, I always get into abusive relationships and I find I'm being raped every night by my husband and he's bashing me up" the first time they talk to someone... but people don't ...know the names... they need to be able to describe it, or they need, from what people are saying, to reflect back to them that what they are describing has a name and tell them what it is...* (B2)

A need for research such as this was also mentioned. *"I'm hoping that by people like you doing this that the information is going to get back to them. "* (Sl) *" Research - the effects on anybody, men and women...just getting some statistics through women's refuge... doctors...bring it together... it's just like an illness...so with emotional abuse there must be some kind of pattern...."* (Cl)

What else do I need to know?

There were a range of responses to this question that included:

> *I think that there must be a lot of people living with hopelessness at the moment, not being heard, cause I know I'm living with it and it disturbs me thinking about that happening to people....* (S 1)

I think that education is the big thing. It would help ... like the power and control wheel on the wall at the play centre, you know, in doctors waiting rooms, places where women are likely to go and ....they can glance at things and they can see things without having to answer the right questions first. So that someone realises. Cause I wonder, if I'd seen those domestic violence things - the woman with the black eye, I wonder if I would have related to them. I'd had a black eye and worn glasses to cover them up, but I wonder whether I would have identified with them at that time, I don't know. And...see they could have put me away, they could have doped me to the eyeballs if nothing else and sent me home, I would have done it - I would have taken what ever they gave me. The most important thing. ...I think is that if people are reporting any kind of distress like I was, I was very distressed, that they are offered refuge. We finished up running for our lives, literally running for our lives because he was going to kill us. (B2)

Women who have only experienced adult domestic violence

The third set of results come from women who have not experienced abuse as children, but have lived with an abusive partner as an adult. One of these women has used mental health services, one works in a mental health service and the other two have used the services of a general practitioner. One of the women interviewed had also been interviewed in the key informant's section, and was re-interviewed for this section. Other women were interviewed for this section, but they had all experienced some form of abuse as children. (see method chapter.)

In answer to the questions they were asked, these women replied:

What is domestic violence?

Domestic violence was defined as "*not just physical - not having respect for other people's boundaries"* (Rl). It was also described as:

... verbal abuse which becomes mental abuse which becomes psychological abuse which becomes heart abuse which becomes spiritual abuse which becomes soul

abuse, all tied up together like a seeping sore, unless cleansed it becomes bigger and bigger ... and that person gets wounded more and more because your defenses are down already or (you) don't know how to defend yourself and in some cases you can't defend yourself, there's no defenses known to man to defend yourself against some domestic violence situations without physically moving out.... You've got your mental abuse which I think is probably in some ways the worst of all because unless you're a person who has ways of dealing with their mental abuse it's extremely hard to get inside somebody's head and get out what's in there ... I don't believe our psychiatric system does it...and that person, not only is their psyche affected, but their heart is affected as well. .... That is the worst. .... The last emotion... feeling... thought, I had when I knew I was letting go of my husband wasn't compassion...I thought it would be...it was fear and it had been there since the day I met him almost.... and if you have fear that deep, who the hell is going to get it out. (J5)

What is mental illness?

Mental illness was described, by all the respondents, as:

Chemical imbalances in the brain that causes what the status quo calls abnormal behaviour, depending on what the mental illness is and what the behaviour is and how severe they are. They can be psychologically triggered but not thinking or acting in the way the status quo does essentially.... It's not being offbeat or slightly eccentric or anything like that. It's not being weak. It's not being quiet or shy or anything like that. (Kl)

Have you ever said or done things that you have felt are signs of a mental illness?

There were a range of responses to this question including feeling depressed, suicidal, anxious, and psychotic.

Only what I would possibly call depression, but I don't think it was clinical. (I had) negative self talk so your own voice in your mind will say things, quite negative things like why should I get up in the morning, what's the point, I'm fat, I'm ugly ...it was actually when I started to feel a little bit better that I actually

recognised, oh my god I'm going crazy, because this is what crazy people think. (Kl)

... when I think back on it, I think about my husband at the time saying: "Oh, you 're mad - mad people act like that." *And even now in a way, that question mark comes in - who's right, me or him? It's his perception of what happened. Is his perception correct, or is my perception correct? Because abusive partners shift your sense of reality and your belief in yourself. I did silly things, crazy things ...* (S2)

Anxiety disorder - normal anxiety gone beyond normal, depression. (R2)

...the only times I show signs of mental illness is when I'm physically unwell with stress on top of it...last year I was really physically unwell and then I had a husband who came home and threatened me and I became really fearful and he had guns ... in his wardrobe and things like that and be would threaten me with them and he spiritually threatened me as well ...I did everything I needed to do to get out of the house but I became psychotic almost... right over the edge. I've never had a real high, I've never had a real low but I've had like a little scenario going on in my head, I withdraw into my own head - but when I do that I ... can still do everything I normally do at home here ... I could still cook my meals and stuff but I did things like put the knives away ... everything that might put me at risk and just did basic things.. (J5)

Have you ever said or done things that someone else has said are signs of a mental illness?

Three of the four women had been told that they were crazy - by their partners, by friends and by the mental health service. The other had been told by a friend to "*... cut her wrists and get it over and done with".* (Kl)

Yes, *my husband - ex-partner. Also others - women friends. At the moment I'm on antidepressants and I'm still being pressured by my ex-husband. I don't know how much that's to do with it.* (R2)

The CAT team, the psychiatrists have said it, but the psychiatrist I'm seeing now doesn't see it as signs of unwellness, she sees it as keeping myself safe. (husband) ...yes he's the one who first put me in Carrington ... his process was that he would come home at night and analyse me from the time he walked in the door. He is an extremely stressful person.... (B5)

Do you think what you were experiencing was mental illness?

None of the respondents felt that what they were experiencing was mental illness.

I would say it's something on the long spectrum of human behaviour but it seems to be defined as mental illness. (R2)

… to some people that's perceived as something crazy. Yet to me, at the time, it wasn't. It was out of sheer frustration and I don't perceive it as being crazy, but it could have been used in a way to prove that, or perceived as not something a sane person would do. (S2)

I'd think that I was going mad and I'd doubt my sanity. I think what helped me believe I wasn't, was feedback from my family and my doctor, in particular. If I'd gone to my doctor (I went a number of times) and... say, you know "I think I'm mad" or "I'm depressed" or whatever, he always encouraged me that I was doing the best thing. He never, ever offered me a pill. I think that... being able to say "Well, hey, the doctor says I'm a good mum." If he thought I was mad or if I was showing signs of a mental illness, he would have given me pills or be would have sent me to a specialist or something. So to be able to go home and say "well, my doctor doesn't think I'm crazy, so I must be sane". (S2)

I know how I felt from an abusive relationship and I felt incredibly bad... You know, I had suicidal thoughts, probably would score quite high in a depression inventory, but it was something that was caused by the situation. (Kl)

What do you think caused you to feel this way?

All of the women talked about their feelings of being crazy - or behaving in ways that were perceived as crazy - as a response to an abusive situation.

> *I used to think that I was mad ... I think... the isolation is there, the loneliness and having only his point of reality as an alternative to your own. When you think one way, he thinks another way - you've got no real contact with anyone else, you actually do think that you're mad. Based on all of those reasons ... you really question, "Well did I say that?" and he might (say) "Yeah, I want a coffee" and you make it for them and they say: "No, I don't want a coffee!" but you're determined that they did, so then you start thinking you're hearing things, and when physical abuse is a part of that as well, you separate. The only physical hiding I ever got, out of all of them, the only one I felt was the very last one. None of the others can I recall feeling his fist touching me or pain at the time,* a *couple of days later or that night I'd feel pain, but it was never - he hit, I felt pain - because the fear and that, and your emotions shut down and you step outside from yourself to a certain extent as a protection. So then you start wondering: "Have I got a split personality because I'm not feeling this?" If he's saying "you're mad" or that "you're hearing things" or that "you're not doing things properly" you put something somewhere, and then it's gone and you don't know where it's gone to. And ... you start believing that you are mad, that you are the crazy one. And when you're losing touch with your feelings ... and of course, you're too scared to be angry so you push the anger part of you away, but then all of a sudden one day, you'll notice a tone of voice, or you're saying things that you normally wouldn't. It doesn't sound like you, but it is you. You start wondering what's wrong with you. Yet, in reality, and quite often not until long after you're out, you actually realise that there was nothing wrong with me. That they were all normal coping mechanisms. I think the hardest part for me in all of my recovery was bringing the separated parts of me back together ... 'cos with it all comes remembering. You remember. When something horrific happens to you and you step out of yourself, you don't always recall what triggered the stepping away.* (S2)

I think it was the result of a situation and when the situation was removed then the feelings and thoughts I had went away. But it took a long time. It wasn't just the next minute ... and next day it was gone. But... I think it was situationaly caused and once I was out of that situation or that thing, then I could get back to what I consider to be the normal me. (Kl)

No. When I went to Carrington I had a physical illness, I had pleurisy, I was totally worn out, I was bringing up two children on my own because we had separated and I had just finished a relationship with someone I was in love with for the first time in my life so I wasn't really sure about my emotions and that kind of thing. My husband came on the scene, cause I rang him and said I need your help with the kids because I'm not well and he rang Carrington because I wasn't sleeping well and he said I was acting strange - but acting strange was I was crying a lot and I may have started to become a little bit high...I can remember every second of that time.... and I can't see he had any reason to put me into Carrington. He rang up the CAT team, they came round, gave me some medicine and said I needed a rest and said they'd put me in Carrington for a few days for a rest. I had some sleeping tablets but I was too afraid to take them, especially with two babies in the house on my own. (J5)

What kinds of abuse did you experience?

The responses to this question fall under a number of headings:

<u>Emotional Abuse</u>.

Stealing your self-esteem, stealing your soul. Abusing who you are - the real person that's you. Taking that person away, belittling that person, just stomping all over an internal you. Not even your thoughts were private any more. And it was all the shit - they kept hammering the shit into your head all the time. Your thought processes get taken over, even to a point, they no longer have to emotionally abuse you, because you do it all by yourself. You get this wheel that just pounds over and over and over in your head that you hear their voice putting you down - all the time. (S2)

He'd do things to aggravate me...just to piss me off, he was very rarely compassionate or sympathetic - in fact he was the total opposite, he might say "get your shit together and piss off to work", something like that. The kids don't need you at home anymore, we need the money, go. (J5)

Not physical abuse at all. Emotional abuse. But...it was like the old fashioned term mental cruelty, because he would tell me that what I perceived wasn't correct - there was something wrong with my perceptions. And that was kind of a routine response if there was any dispute between us.... (R2)

I think lying is one of the most crazy making things that one person can do to another person. (R2)

...he's been bullying and harassing me since I left – even although it (was) his idea - over my daughter... its gone on now for three years and he's still pressing for access. (R2)

…he would for no reason fly off the handle for me not keeping the house tidy and he said the place was starting to look like the house he lived in when he was a child and it was a pig sty... (K1)

... he would say things like ... I was starting to look quite dowdy and could I not come into his work anymore because he was embarrassed by the way I looked. (Kl)

“You're useless" ...he was working, bringing home, like earning $500-$600 a week, bringing home $80.00 and out of that $80.00 I was supposed to pay the mortgage, food, power, phone - the whole lot. And Saturday would come: "Where the fuck's the pork roast! You know I like pork - oh you fucken useless housewife." "You're supposed to be, you know, a wife should be providing decent meals, and you know, I gave you the money."... And stuff like, “I got offered to go to a party tonight, but I came home because I love you. This woman come onto me at the pub, but no, I told her I love my wife." ... Well, if he's being offered sex,

well maybe I should do it, you know, give it to him.... He used to make me doubt myself. (S2)

Psychological was the worst .... he mentally and psychologically abused me and controlled me before he ever hit me, and I think (it was) about five months when he hit me the first time, and even by then I couldn't leave. I believed that he would love me again ... he'd say "Well, please don't leave me and if you do, I'll die without you" kind of bullshit, and I was dumb enough to believe it. (S2)

(He told me) that I was getting fat, that I was lazy, that I used him for his money, that I was just like his last girlfriend who used him for his money, and all women are the same...I don't think he ever said that nobody else would ever to go out with me, but that's how he made me feel. (Kl)

Sexual abuse

One of the worst I think was, when I first left him five years ago, I would have said: "No, he didn't actually sexually abuse me in any way." Four years into my recovery, I realised that he had. Not in the sense of forcing me, or forcing me into acts I didn't want to do — more that I wouldn't want sex, he would, but out of fear that, well, it's easier to give in than be beaten up for it. Or easier to do this, than ... what could he do that's going to be worse? Or ... if I sort of said "No", well "I'm going to get the big fucking pipe and I'm going to beat the crap out of the cot to see how long it takes to wake up our son." So it's kind of, afterwards, you're realising "Hey, that was really horrific, that was rape - I didn't want it, he did it. (S2)

And with the sexual, I came to a point where my body was all that I had left control of, so I would deliberately not give him sex because it was the only part of me I had left to be in control of and I remember going into bed wearing, like, nighties to my neck and really long, and tucking my feet in the bottom - basically,

tied up in a knot so that when he'd come home from the pub, he'd give up, you know because he had so much clothing to get through. (S2)

I'd always known he was a chauvinist but I didn't feel it did any harm but I feel differently now. I found out he used prostitutes...I can't put up with that, it's complete exploitation, I felt sick. (R2)

... if I wouldn't give him sex he'd grab me by the pubic hairs and drag me around the bedroom, he's raped me a couple of times ... my son was conceived through rape. He nearly killed me through not listening to me when I had a ruptured eptopic pregnancy ...and left me at home... (J5)

... he would treat me like a, essentially like a slut, because all I was there for was to have sex with him when he wanted it and that's really the way it made me feel ...we carried on like that for about a year. He'd get very angry and yell and scream and argue with me and he would essentially force me to have sex with him when I didn't want to. (Kl)

…then he started stalking me and he'd be sitting outside the front - it got to the point where I actually gave in for a while, it was easier to give in and have sex with him when we were broken up than having to put up with all the shit he was causing by stalking me. (Kl)

.... then he went and got the girlfriend and I think he found it either exciting or flattering that he could have a girlfriend and still ring me up every now and again for a shag ... But I knew if I didn't, he would make my life a living misery. (Kl)

...you might start out initially not wanting sex with the guy, but then it was almost like your body would be changing, because the physical would take over and you'd want to, that wasn't fair. You know, afterwards you'd feel like a real deep sense of shame, like: How could this man who has done these horrific things to me, how could then I turn around and enjoy sex with him? So there was a real

sense of betrayal of yourself and that's quite mind twisting to come to terms with. .... I can understand how sex can be a catalyst to actually cause woman to go back into violent relationships. That's the hook that they get drawn back in on. (S2)

Intimidation

The first one...and why I ended up with the fear, and why I married him was because I was frightened of him, you know, I did love him, I thought, but now that I know love I know... it wasn't love at all...and I was a young girl and... The first time it happened he was drunk, it always seemed to happen mostly (NOTE mostly) when he was drunk, he punched me in the face and pulled out my hair, that was the first time and there were several other times when be would just use - he was a big man - he'd use his body to threaten me, or he'd just slap me round a little bit. (J5)

We'd have an argument or something and he'd sit - he knows I hate guns, he left a gun loaded one day, he's not a stupid man he's a farmer...my son came out with it... he'd sit down of an evening, if we'd had an argument, he'd go away, get his gun and just sit there cleaning it. If that's not mental torture, I don't know what is. (J5)

... he got incredibly nasty and then he would get incredibly drunk and then he would get incredibly pathetic, and he'd do that all in one night, but he could only ever do that when we were alone. (K1)

Physical abuse

He wouldn't come home at night....I used to pick him up. One night...I was 8 months pregnant, I had (her daughter) in the car... I picked him up, he was drunk... he was arguing that he should drive and I said no, he biffed me and I saw stars ...we stayed on the road and I just vomited... this is a man who sent his wife

off to mental institutions ... another time he wanted to drive and I wouldn't let him so he put his fist through the window. (S5)

...He shot a shot gun off in my ears and burst all my eardrums (J5)

Did you tell anyone about it?

Three out of the four women talked to someone about what was going on. These people included a friend who is a therapist, *"She did warn me a bit about him"* (R2) people from church, mental health services, friends and family. This has had mixed effects in terms of usefulness.

Two different responses. The family one was, "did this happen?" and he denied it, and I slapped him, and they went "she's the violent one in the family"... With the separation we got the same family counsellor again ... and he (her husband) just denied it. Unless he's willing to change, nothing's going to happen, they can't do anything. (J5)

One woman eventually went to relationship counselling, provided by the courts and this person identified her experience as abuse and referred her to a domestic violence service. A previous counsellor that she had been to with her husband hadn't seen what was going on. "*... she didn't pick it up, she never acknowledged it. I doubt that I ever accused him of it actually. What I felt was that he was being untruthful and wouldn't stick to the facts."* (R2)

Another woman had support from a woman in her church, who raised the subject of physical abuse and offered her a safe house. This lead eventually to her making contact with refuge. The minister of her church was also helpful.

One woman told no one, but her friends picked up bits of the story.

No, some people know bits... because I was ashamed it wasn't perfect ... I was ashamed by what he was making me do. (Kl)

Have you had any contact with mental health services - did you tell them about the abuse?

Three of the women have had no contact with mental health services for the abuse they experienced - although one woman now works for a mental health service.

> *None whatsoever. When I left him the last time, I got really, really depressed and I wonder now, looking back, would it have been helpful - would medication have been helpful? I don't know and I don't know if I would have taken it.* (S2)

> *No. I suppose I was diagnosed as being depressed along the way at some point - even although I took anti- depressants during the marriage at some point, maybe more than once, briefly, but I didn't talk about what was going on in the relationship.* (R2)

The fourth woman has had a number of interactions with mental health services, including periods in Carrington hospital. No one asked her why she ended up in a psychiatric hospital with pleurisy.

> *No, they didn't even ask me that..... They never found out for ages down the track when I started counselling,* (how did you feel about that - that nobody wanted to know about you?) *Pissed me off because the same thing happened after Te Atarau, but it's changed a little bit, but nobody asks you about your relationship and if there's violence and stuff.* (J5)

> *...oh no the first time, that was really new to me, I was only young and to me, ...I was a nurse, the first thing you ask is why are you here. I wasn't even medicated at that stage, you know, what are you doing here? ... I didn't feel I was a person... I felt I must be crazy because I'm here, or there must be something terribly wrong with me because I'm here, even though I knew that just the day before, ... had been a bad incident.... I felt my status within the community went down about to zilch, I felt my whole being, right throughout my whole life, had just floated out the door, plus I was in a place I was absolutely terrified of and had never been to in my life, locked in there and people couldn't come and see me and I had a wee baby who I was breast feeding and I couldn't have her and that still upsets me to*

> *this day.... and there was this man, who I'd been separated from for two years who was calling the shots.* (J5)

She subsequently told people in the services what was going on - *"...but I told them this time - I don't want him anywhere near me and if you see that vehicle come I want guards on the door, I don't want him allowed inside, I don't want any telephone calls. I told them why and they were really protective of me"* (J5) and they responded to this, "*... they set me up with how can I look after myself in those sort of situations and who to ring and what to do...a plan of action....they also gave me psychotherapy which was really helpful, but it can only go to a certain level..."* (J5)

She also mentioned that the therapy she eventually got from a mental health service was *"trying to get me to change....to be able to cope with him, which is wrong... relaxation techniques and all that crap..."* (J5)

What should happen?

One of the women who answered this question felt that the only thing that would have helped her was her partner taking responsibility for what he was doing to her. The others responded in various ways:

> *...for them to help me work through the grieving process of the physical, mental and spiritual violence that I was going through.* (J5)

> *I think if people — if somebody had allowed me to place the blame somewhere other than myself.... at that point I needed somebody to tell me what to do and what would make it all better... sometimes all people want, for somebody just to take over and take control until you can get better.... But I think if somebody had just said "ok, you're going through this." If somebody had explained what was going on, what was happening and told me what to do, or even if they'd just been there - they'd said, you know "you've got to be strong, or change the phone number or move or whatever" to make him go away.... Yeah, it would have had to have been that direct... Because I was so embarrassed, so ashamed.* (Kl)

What would need to happen for these things to occur? - What do mental health services need to know about domestic violence?

Three out of the four women answered this question. For these women, training and screening were major issues.

> *...need to train people...those who need it need to have the option to leave the (violent) environment without the obstacles there are now.* (Should mental health services ask when people first go in?) *I think they should ask at the first telephone call. Not just mental health but all these telephone services that are running.... (so that) people never get into mental health services...* (J5)

> *I think that when people are screened or in their initial assessments, we need to know all of the contributing factors. So ... we need to know about... abuse, and we need to know about relationship situations, so that means not only do they live with mum, dad, partner, whatever, but what is their relationship to those people?* (K1)

What else do you want to tell me?

> *I haven't been abused in the past, but for some reason I think I'm vulnerable to emotional abuse, but having said that, I think everybody is. I think you can be as sane as anything, as together as anything and repeated messages to you that really are damaging can make anybody crazy.* (R)

> *I think what always keeps driving me is, and I think when I thought about coming to this interview today ... around when you first used to say to me "Women used to say 'he drove me mad' - you know, what is it?" ... And I think... it is around ... these women really think they are mad. They do. The guys drove them to it and ... it's a combination — it's the fear, it's the isolation, the fear of being hit, the fear of being abused, not being able to express your anger and the cutting off of your own feelings - it's that disassociation from pain, and a total doubt of reality, is your perception of reality truth or not? And I think it's not 'mad' in the mental health illness term... if anything, these men are the ones who are sick and a lot of women - and I did it when I left my husband - I was sick ... and I was depressed, I*

> *had no sense of self-esteem, I had no idea who I was and some days... it used to take all my energy to get up in the morning and make it through that day, till that night, and it was not because I was depressed or because I had a mental illness, it was because the sense of who I was had been stolen and abused.* (S2)

My thanks to all of the women who have shared their stories and their knowledge with me.

Why doesn't she leave?

A number of reasons why women stay in abusive relationships have been identified by this research. These are:

• Women not having the language to describe or name the circumstances that they find themselves in.

• Women not having information about options and alternatives to the current situation.

• Women not having the time and energy to reflect and think about their situation and possible alternatives.

• Women not having support for change.

• Women being blamed as the cause of their own circumstances by all of the places that they seek help and support.

• Women being labeled 'mental' or crazy and no longer being perceived as credible witnesses to their own experiences.

• Societies innate distrust of women and its proclivity to trust and believe men.

• Societies lack of understanding of the dynamics and insidiousness of domestic violence.

• That women are socialised to be subservient, to work on their relationships, to take responsibility for what happens in the family/relationship, to not like conflict and that conflict and assertiveness are unladylike. When they have integrated this learning into their behaviour, women are then blamed for behaving in these stereotypical socialised ways and staying with abusive men.

All of these reasons are failings of our societal systems and beliefs, none of them are individual or (female) gender specific. What they tell us very strongly is that, as a society, we need to become educated about domestic violence and begin to put services and structures in place to ensure that the inequity identified in the above list does not continue.

Does childhood abuse - as well as adult - increase the likelihood of contact with mental health services?

In this study, the number of women who had had contact with mental health services was slightly higher for the group of women with a history of abuse in childhood. The association in this study is a direct result of the pool of people that the sample was taken from. A much bigger study would need to occur to enable any association to be drawn between these two variables.

Among the group of women, in this research, who had contact with mental health services were some who had been abused as children and some who had not. Three of those who hadn't used mental health services, drawn from both groups, currently work in mental health and at least three of the people interviewed as key informants have had personal experience of domestic violence.

Themes

The themes that emerged were the same from both groups of women - those who had been abused as children and those who hadn't and also from the key informants. Therefore the themes that emerged from the research will be exemplified by comments from all of the interview streams. The themes are very interconnected. However, each one exemplifies an important component of the results.

Six major themes were identified from these interviews. These were:

Theme One

Abuse, especially emotional abuse, makes women think they are crazy.

• By invalidating their sense of self.
• Physical and sexual abuse compound this feeling - as do other stresses in a woman's life.
• This happens whether a woman has been abused in childhood or not.
• The symptoms of having been driven crazy can be perceived as mental illness.
• It's not, however, mental illness, but a reasonable response to circumstances.
• A 'breakdown' or depression can occur quite sometime after the relationship is over - but is still connected to it.

This is the pivotal theme, around which the others revolve.

When people think about the effects of being in an abusive relationship they frequently think primarily of the risk of physical harm and the ever present risk of murder. The women who participated in this study identified the emotional and psychological effects of abuse, as outlined above, as being most significant. These behaviours were not identified as pathologies, but as reasonable responses to the situation the abused women lived, or had been living, in. From the discussion, it became apparent that these behaviours could be perceived as evidence of diagnosable mental illness.

The participants talked about "post traumatic stress disorder", "anxiety disorders", "personality disorders" and chronic mental illness such as "schizophrenia" and "bipolar disorder". These are labels that the participants had heard being applied to the women they are working with, or to themselves.

> *We have had a woman (in a refuge) who was diagnosed with schizophrenia and she said it wasn't true and she wasn't on medication and would have nothing to do with mental health services...* (S3)

The behaviours that the participants describe as being manifestations of abuse can be interpreted as aberrant behaviour, or as realistic responses to the abusive, controlling situations the women have been living in.

> *Women need quite a substantial time of safety before the paranoia...drops and she should not be counselled, she should not be therapised (sic), she should not be medicated, she should not have a DSM IV...* (PI)

Continual vigilance, fear and anxiety are responses to continuous monitoring, threats, intimidation, verbal abuse and the constant control of a person's behaviour. Disassociation, blocking and drug and alcohol abuse are a reasonable response to physical and sexual pain and abuse. Lack of self-esteem and the concomitant inability to organise one's life, motivate ones-self and/or developing the need to be totally in control, can be seen as predictable outcomes of the previously mentioned situations.

> *Not post traumatic stress disorder, it's a label, ... it's (the) normal effects of violence...sure women get flash backs, get triggered, remember... and all that, but*

it's different...no need for it - why do we need a label when it's simply an effect of male partner violence...the symptoms are multiple... (PI)

The majority of women I meet have been through some of the symptoms - at some stage you could mis-label them quite easily...you think, it's a very fine line between having a husband who checks up on where you are and monitors you constantly and being paranoid. Half the mental health people just don't believe what these men get up to - they're not aware of predatory behaviour. (Hager 2000)

The women all identified emotional abuse or 'mind games' as the part of the abuse they experienced that made them feel crazy.

That's (the mind games) how I ended up thinking I was crazy. (Al)

They (mental health services) need to understand... that...the more damaging part of domestic violence is actually the unseen part, the emotional. I think that's where the connection is (with mental health). *If you can imagine if someone is taking abuse all the time, and someone is telling you you're no good and someone is telling you can't do something, how are you going to end up? You'll end up feeling ...I'm just here to be used and abused, I'm not worth anything else, I can't do that so I won't do it. You'll have no goals, no thoughts, you'll just get by day by day. For me that was the connection, it wasn't physical — the worst part is the words, the words are really cruel...Sticks and stones will break your bones but names will never hurt you...but it does hurt. After* a *while you build up a wall, and it's not to protect you, cause what really happens is you block all that in there and you can't develop as a real person, cause you've got all these walls. You know if you're hurt once you build a wall and it just gets built on. You develop coping skills but you never deal with the problems...you don't let anyone see the problems....* (Cl)

I think you can be as sane as anything, as together as anything and repeated messages to you that really are damaging can make anybody crazy. (R2)

> *I think probably the most damaging is the psychological violence people are subjected to because it's the most insidious.* (J3)

This happened because emotional abuse invalidated women's experiences and sense of reality, leaving them nothing concrete to hang on to.

> *..I think because reality is denied to abused people so often. It seems to me that most abusers, because they minimise the violence they're perpetrating, because they minimise everything they do, they are denying reality all the time so the person's reality is being denied. Because, if you're an abuser, you can't keep bashing someone up and own it, because everyone knows that it's wrong, so what you have to do to keep bashing someone up is to deny it and to tell the person that it's not happening to you and so you're constantly having your reality denied to you and I think that long term that's very eroding and an awful event for people. I think of it in terms of guy ropes. What grounds you, what holds you to the earth, when that's removed from you, then you loose all sense of who you are and what is real.* (J2)

> *In my own experience I've seen how you can drive somebody mad by telling them that what they experience is not what they experience....When your reality is taken away it makes you crazy.* (Jl)

The women feel this way whether they've been abused as children or not.

> *Regardless of what happened as a child ...this makes anyone feel bad.* (Sl)

Emotional abuse erodes self esteem and one's belief in ones self and causes women to doubt their own perception of reality. When this occurs, sexual and physical abuse reinforce their feelings of unreality and lack of worth.

> *It was so drummed into me by my husband that I was no good and the bashings were wearing me down. Sometimes I'd be in bed for three or four days after a*

bashing and I wasn't allowed to get any help and I thought, something has to give. (B 1)

This all culminated in a very pressured period of time ...there were a few times that he hit me ...you know I thought I was going crazy... (B2)

Many women go on coping for years before they feel like everything is falling to pieces. Often their partners carry on abusing them long after they have separated and completed divorce proceedings. For others, even although they no longer have contact, the effects of the abuse persist. Sometimes, it's the stresses caused by other events in their life - parents ill or dying, financial troubles, problems with their children - that precipitate a crisis time.

....marriage breakup, mother in law died, finances, he wouldn't talk to me, he'd get the kids to talk to me... it's like, he's down in Dunedin now, he's still trying to use that control - then my Dad died .... about four weeks ago I felt it's not worth it, why not end it all ...Oh God, I'm going crazy — every time I took a step forward I took four back. I was beginning to give up. For a week I was going through the motions ... went to the Doctor, he said you're severely depressed. I didn't want to go on drugs.... I wanted to sit on my bed and just cry, drink my self stupid or take pills... there was a time when I just thought I wouldn't tell anyone, I'd just slip away... (C 1)

It's quite interesting, in the last few months, we've been separated three years, I've had a bit of anxiety again for the first time. I've literally doubted my perception of reality... Over the Christmas New Year break I got so wound up that I stopped trusting my perception of ordinary objects ...I said this is crazy - first time I've ever said that I'm crazy. (R2)

... so *five years out of an abusive relationship, 12 years since my previous pregnancy, now feelings of madness and questioning my sanity as a pregnant woman...* (S2)

Whenever it happens, the symptoms that the women manifest can be perceived as mental illness and women can find themselves treated as 'mental' patients.

> *...I said look, I can't go to a hospital, there's nothing wrong with my body. If it's a mental hospital there's something wrong with my brain because I'm tired mentally of trying to cope, so that must be where I'm meant to go.* (Al)

Women also reported feeling suicidal, wanting to kill their husbands and hallucinating. Because no one asks the women what precipitated their crisis, behaviour that could be interpreted as a rational response to circumstances is instead interpreted as pathology.

Theme Two

The effects of being labeled

- Hospital
- Drugs
- Not being taken seriously
- Finding it even more difficult to cope

A number of things happen to a woman when the behaviours that she is manifesting become diagnosed as a mental illness. Firstly, she is given a label that carries with it a lot of negative stigma and association.

She is usually medicated, put into therapy and sometimes given shock and other treatments. All of these things further decrease her ability for reflective thought and/or her ability to get out of an abusive situation. Once labeled mentally ill a woman becomes a suspect mother - agencies charged with the care and protection of children are not inclined to give custody to a 'mad' parent, which increases women's levels of anxiety, fear and vigilance. Other agencies also become suspicious of her and do not give credence to her testimony. (Theme three).

The other thing that occurs is that a label of mental illness increases the abusers power over a woman.

> *(I)...know a woman...her abusive partner uses her illness as a way to control her - if she expresses some kind of emotion her partner will yell at her and tell her to take her pills...* (Hager 2000)

An abuser knows that a woman will be frightened of losing her children and so he will have an extra lever for abuse and control if she has a diagnosis and/or medication. He can also be a sane charming person when the police are called by the 'mad' wife.

> *...one case in particular, the charges are always dismissed in front of her...the guy comes to court and he's not crazy, she is, and she has a long history of mental illness — but the fact is he still abuses her horrifically - but the charges are dismissed.* (Dl)

Once women are labeled as mentally ill everything they say and do is interpreted as being a symptom or manifestation of their illness, rather than being a legitimate concern or reaction to circumstances.

> *I don't see that what I see as quite normal responses to living with violence should be pathologised. There are unpleasant and probably quite appropriate responses to violence...I'm inherently cautious about how women get labels stuck on them, because they respond in perfectly normal ways to certain things that the medical model may not otherwise know how to deal with.* (J3)

Women's experience of this phenomena was explained in the following ways. *"They were treating me for all these things, bipolar, schizophrenia ... but I wasn't responding....I was on fifteen drugs three times a day...I became an addict because of the drugs..."* (Bl) This woman had been hospitalised by her highly abusive husband - but no one had asked or listened to what she was saying about him. Her anger about him and what he had done to her was interpreted as symptoms of chronic mental illness.

> *I think all the labels I've had from people minimised how dangerous and unpleasant my experiences have been.* (S 1)

"That's when they put me on a whole heap of drugs that made me really out of it (after she had been raped in the psychiatric hospital).. .*That's when they gave me the diagnosis of bi-polar..."* (J5) This woman was also hospitalised by her husband. Again, no one had asked how or why she had ended up in a psychiatric hospital, ill with pleurisy.

> *I haven't had any sign from any psychiatrist... that my anxiety and fear are normal and are linked to other people's behaviour and actions towards me...* (S 1)

This was explained by key informants as:

> *... there's a kind of attitudinal violence about mental illness anyway, where people are held to ransom and in a position of powerlessness, because they have a mental illness ... like the way they get spoken to by their families ... the way they get their lives controlled by other persons - be it their partner, the system...* (J3)

Even if women are not hospitalised, they are likely to be prescribed medication when they seek help for domestic violence. This reinforces the fiction that they are to blame for the way they are being treated by their abusive partner and it also makes it more difficult for them to function and protect themselves. The women accept the medication because they have been conditioned, by their abusive partner and sometimes by other people in their families or communities, to believe that they are in the wrong.
One woman was offered, and took, psychiatric drugs *"because I thought I was failing as a wife and mother - I didn't know any better."* (B 1). A psychiatrist at Sunnyside hospital prescribed the medication.

> *...See they could have put me away, they could have doped me to the eyeballs if nothing else and sent me home, I would have done it - I would have taken whatever they gave me...* (B2)

Once the women are on the drugs they have less resistance to abuse because they have trouble functioning.

Theme Three

Services deepen and reinforce the feelings of abuse.

- What they say
- What they do
- What they don't do**.**

As mentioned in the second stream, there are many circumstances where agencies appear to be working in collusion with the abuser - or at least, not in the best interests of the abused woman. Even agencies mandated to help women escape from domestic violence may not be useful to women who do not fit defined behavioural parameters.

> *...secondary abuse by institutions - that's one of the most predominant factors in sending someone mad..* (Hager 2000)

> *...fear of him isn't necessarily accelerating - that's as bad as it is - but everything else that you touch...trying to get assistance from all the other agencies...a smorgasbord of disarray... a huge amount of extra stress from seeking help… often institutions give no help, no support from friends, family, community...* (Hager 2000)

When women have contact with mental health and other services, the behaviours they encounter frequently reinforce or mimic the abusive behaviour that they experience at home.

> *Mental health and service providers replicate the violence that people have suffered in their homes ...we keep people labeled and put in their place and treated a certain way because of our beliefs or ...what ever has been decided about them and keeps them powerless, and we carry that on.....Domestic violence becomes system violence in a way. And we're so busy treating the symptoms ... I mean the medical symptoms ...I can guarantee that when we go to a meeting we spend two thirds of it talking about medication to use, instead of spending an appropriate amount of time looking at what does this person need other than medication.... suggests to me we're not focusing on the right area and we're just perpetuating the problem really.* (J3)

> *One psychiatrist sat in a meeting talking about adjusting a woman's medication - he's had her for years - and he made a joke about how every now and then the husband put a gun to her head...* (PI)

Another example of this is the mental health professional who talked about:

> *... so say for example, someone's hearing voices, you might do some analysis on where that might have come from, but really today that's what we have to deal with, is that experience, so that's what is happening in the here and now and that's very distracting in the art class that you're attending, how are you going to deal with that, so a very practical response to dealing with life and life issues – as opposed to needing to analyse where it's come from.* (C2)

This lack of inquiry about causation, and the concern about 'distraction in the art class' resulted in situations such as the following:

One woman, when she talked about her husband's on-going adultery, was asked by a psychiatrist why she hadn't had affairs herself. This same woman was used as an exhibit in front of a panel in a lecture theatre full of medical students - without either an explanation or being asked for her consent. She was talked about as a *'very strange case'.* (Bl)

Another woman talked about the mental health system feeling like "*an abusive partner or parent or something because I'm doing all the changing and I'm getting blamed... It felt really intimidating ... that position we had with this man just sitting there engaged but not engaged in it. That made me feel suspicious about how they were using power and control"* (Sl)

This woman went onto say "*... rarely have I had any positive comments e.g. it's amazing that you're as together and well as you are, considering what you have experienced. That would be nice."* (S 1)

The lack of acknowledgement of causation was general throughout the services women accessed. "I *suppose I was diagnosed as being depressed along the way ... even although I took anti depressants during the marriage at some point, maybe more than once, briefly, but I didn't talk about what was going on in the relationship..."* (R2) and no-one asked.

Another woman said**:**

> *... I think, to have had somebody actually talk to me before I actually got put on the ward so that they knew why I was there, and it wasn't for a rest. Somebody should have clicked and thought, if she's mentally exhausted, why? She's so*

> *young, she's only got two children. It's not like I had ten or six. Somebody should have clicked.* (A1)

A number of the key informants were very aware of the power of the system to re-abuse.

> *The system has to watch that it doesn't become the abuser, so in trying to be nurturing or caring you can end up being very paternalistic* (C2)

Even in situations where the abuse woman experienced was finally admitted, no one made a connection between the woman's responses and so called mental illness and the abuse.

> *What really fucks me off ... is that these men never get brought to justice, while the likes of myself have to go through all the ... stuff that's around because of what's supposed to be wrong with us and yet there's nothing wrong with these people who are causing it...* (J5)

Another woman feels that her experiences of abuse have been heard but even so, the staff have given her plenty of information about schizophrenia but none about domestic violence.

As one woman points out, when abuse is recognised, it is still the woman who is seen as having to change. Some of the women have had therapy which has tried to teach them how to cope with or minimise the abusive behaviour by placating their partners.

> *We live in a society where it's seen as not normal for people's lives to get so difficult that they're not coping emotionally and I think it's normal. I think what's not normal is that we don't have social systems ... to deal with that so we put a label on it.* (Jl)

Many of the experiences women have had with the above services are replicated with lawyers, courts, refuges and other services.

> *We have all these screening questions for refuge ... I think for those women it's ... difficult. If their form of mental illness is non-disruptive and non-psychotic, some*

refuges will take them. And help them. But it's kind of double whammy for the women who have acting out problems, who are disruptive, because those women are required to hang out with other mentally ill people ... hanging out with dangerous men because that's your peer group.... stigma in refuge - (It's) not true of all women who work in refuge but they'll go for the easy option and a psychiatrically ill women isn't an easy option ... you can't get refuge for psych people and A&D (alcohol and drug addicted people) (J2)

...there's also all the stigma associated with seeing the woman as mad and I've had men saying that about their partner, because they come here, "you're loopy, you're crazy, you're mental." Often in custody disputes it can count against the women that they've been part of a mental health service, whereas the man has not, so the stigma is often very difficult. (Rl)

I guess the women I see are being abused by the system as well - worn down by that...because the whole criminal system doesn't treat victims well, we don't look after our victims and the courts don't — they get worn down by the whole system. (Dl)

Refuges don't want to know our women because of the mental illness... (Ml)

Often what the system isn't doing is as insidious as what is happening. One of the main things the system - other than domestic violence specific services - doesn't do well, is protect women from on-going harm. These failings include not hearing what women say, not having resources available and not intervening.

Eventually, however, some of these women do meet someone who hears what they have to say about the abuse they experience and respond constructively. This is not, however, common.

Theme Four

Women's explanations of their own experience are either not believed or reinterpreted

This theme exemplifies the vicious circle of being labeled mentally unstable - i.e. once a person is mentally ill then everything they say becomes suspect. But it also demonstrates how suspicious people

are of woman's testimonies generally. Women are not perceived as credible witnesses to their own experience.

> *I would have liked to have been listened to ... but really listened to. Not just the thing that seems to have happened where people seem to want to talk at me rather than collect what I'm saying. ... I couldn't get through to people that it doesn't matter if a person* (the perpetrator of abuse) *is sick or not, abuse hurts anyway. They all seemed to think ... I shouldn't be hurt by it and I found that a bit crazy...* (S 1)

> *I'm very nervous about going through court. He's a very powerful, plausible man and I just shrink when I'm in the room with him - not always of course ... but in that sort of setting I feel beaten before I start. He's got custody of two sets of daughters before. The fact that he's got this far when he's not her father just astonishes everybody - it doesn't astonish me - he's impressed the professionals all the way along...* (R2)

This especially happens when a woman is put into a psychiatric hospital and her attempts to talk about domestic violence, and to have her experiences recognised and legitimated, are interpreted as attention seeking, ignored or minimised.

> *I would have liked to have been able to talk off the record, although nothing was off the record there. First of all it was called attention seeking because I wanted to talk. So the word went round, "don't take any notice of B, she's attention seeking… put her in the fish bowl"... I'd get punished because I wanted to take my anger out on me or someone else.* (B 1)

> *...because of some professionals causative beliefs with their emphasis on genetics they miss the importance of violence as a causative factor and especially in the more severely disturbed ... but as you go up the severity scale towards the end that I deal with in my work, in some cases there's a pretty strong assumption that life events are not really relevant or they just trigger off the underlying illness*

...so people with biological beliefs are less likely to ask people about violence and therefore to respond appropriately. (J4)

Theme Five

Abuse must be named

• Consistently and without judgment

• Healing won't occur without naming and acknowledging

One of the recurring themes in the research was that women, when they were living with domestic violence, did not have the language to talk about what was happening to them. The other side of this is how valuable it was to be given the language so that they could identify their situations and speak out about it. Many of the women I spoke to had never seen information such as the power and control wheel, or been given any explanation or analysis of abuse with which to name their experiences.

...it would have been helpful for her to name it abusive, frightening, and dangerous. Instead we talked about symptoms ... She didn't say what power and control meant or show the Duluth model wheel... I would have found it very useful... (Sl)

One woman had even been told she had Post Traumatic Stress Disorder, but still received no explanation of the dynamics of domestic violence.

Not being physically abused made it more difficult for women to talk about their experiences and access help. They felt that their experiences of abuse would be devalued because they weren't being hit.

...nobody believed me where I went, when I was saying what I was coping with... I felt nobody would believe me if I spoke up about it and if I did they would say, well you're lucky he don't (sic) beat you up because he could do that... (Al)

I don't think I knew that the verbal side of it was domestic violence... (Cl)

Another woman went to a refuge and was given information. She only stayed a few nights and felt that she was too distressed to comprehend what she was reading *"...because there were still feelings of adornment (sic)* ..." (Tl) Another went to a counsellor who said "...I *think what you're describing is abuse ... I said look, I've never been physically abused — and she said, I'd call that abuse."* (R2). This woman found acknowledgement of her situation very useful.

The power of having language to describe your experience is expressed by these comments.

> *If someone had explained what was going on, what was happening and told me what to do, or even if they'd just been there...* (Kl)

> *Knowing what I know now, would have been to tell me I was being raped which I didn't know - and to have told me what I could do about that which I didn't know either. I didn't know there were women's refuges and I didn't know I was being raped and I didn't know I was being abused and I didn't know that what was happening to me was called domestic violence and any of that information would have been useful to me ...* (B2)

One of the important things about being able to name abuse and name what is really going on for you is then being able to begin healing.

> *You can't solve your problems if you don't know what they are. But once you know what they are, or understand what they are, you can make the healing process start.* (Cl)

> *...* a *lot of healing for ordinary women was helping them name their reality because they'd had it taken away from them...* (Jl)

This suggests that specific interventions need to occur, to enable this to happen.

> *...* A *specific intervention that assists women to find their voices again and to be able to name stuff that happens to them...* (Jl)

Theme Six

Domestic violence is more confusing because of socialised expectations of marriage and romance- This theme expresses the ambivalence women felt about their relationships. The women in this study had the usual expectations of relationships that we are socialised to have in New Zealand. These are that marriage - and other relationships - are about love, respect and support between partners. Most of the women felt that they would be with their partners for the rest of their lives. It is partly the disjunction between the socialised expectations of love and marriage, and the reality, that caused women to feel crazy. This is summed up in the following quote:

> *This man is the man you love, he's the man - if you married him, it's the man you chose to spend your whole life with. He's the father of your kids, he professes daily that he loves you and your mind cannot comprehend, if this is the man I love or he loves me - how can he do this to me, to our children? And that's what hurts, you know. It's like I think, home invasion by a stranger is devastating and it's awful and you hear some of the public outcry about it, but when the person who abuses you is somebody that you love, you don't necessarily love them at the time, but it's more devastating to the soul. Hearing my husband handcuffed in the middle of my lawn, screaming out to me: "Is this love, S? Is this love. You've got me handcuffed, is this love?" I've listened to that man for an hour telling my father and me how he was going to slice up our son in front of us and put him in a bag and he'd be so cut up, he wouldn't be recognisable. That this child was a bastard - and it was his son. And then as soon as the Police arrived, ask me if it's "love". And that's when I realised that he was the mad one, because if he really loved his son, why had he put my father and I through two hours of hell, of listening to him talk about how he was going to kill him? You know. The sad thing ... I think, and it's taken a long time to understand, that maybe... is ... deep down in my heart, I have a lot of feelings for him. But I had to protect it, I had to hide it, I had to cover it up from myself, 'cos it was the part of me that made me vulnerable to him. I loved the man I married, I loved the man I chose to have a child with - that man is no longer here - if that makes sense. I couldn't even say to my family that I still love him because they won't understand what I mean. I love the man who offered me the world, who offered me a white wedding and a home and lots of children, and I honestly believe that when he made those*

> *promises, he meant them. But his sense of the use of power and control and the way a man should be ... killed his ability to think and to behave normally. He's now in another abusive relationship. He's no different.* (Sl)

The concept that 'this is the man who loves me' adds greatly to women's sense of confusion.

> *I mean this is the man who loved me for goodness sake. Why would he want to hurt me?...* (Al)

> *I guess when you get married you think everything's going to be rosy and you'll change the man. ... In 1958 I thought I could change my man and grow up and have a family and live happily ever after...* (Bl)

Two of the women had not known their partners very long before they lived with them.

> *You know that whole kind of beginning of a relationship with the rose coloured glasses and we moved in together very quickly and he asked me to marry him and I thought "oh this is wonderful"...* (Kl)

> *...it was just the fact that I married him fairly quickly ... I absolutely trusted him, I felt I knew him well, but I didn't.* (R2)

Other people felt that other people's expectations about relationships added to their problems. *"And my mother was into, when you get married you stay with him no matter what. So I never ever told her about it."* (Al)

There was also the feeling that marriages must last for the children. *"I come from a broken home so you put up with it, trying to think of them".* (C 1)

Conclusion

This chapter is a collation of the results obtained in the interviews that were carried out during the research. There is a lot of similarity between the three discreet groups of interviews, suggesting that women's experiences and understanding of their experiences are available and explicable to those who

are prepared to take the time to listen and believe what they are being told. Individually, these women's stories may not seem credible - may seem to be imagination or exaggeration. Taken together, they paint a powerful, sad and compelling picture of suffering that has been initiated by partners and contributed to by many of the people who are mandated to help.

Discussion and Conclusions

> *... it used to take all my energy to get up in the morning and make it through that day, till that night and it was not because I was depressed or because I had a mental illness, it was because the sense of who I was had been stolen and abused.* (Sl)

Introduction

This chapter explores, in depth, the ideas and themes that have been identified, and extrapolates specific information about what women who were interviewed during the research want and need. The following discussion about the response of mental health services suggests that mental health services screen for domestic violence at first and subsequent admissions to their service, in order to refer women to appropriate services as soon as possible and to prevent inappropriate treatment. This is followed by discussion about the role of the public health/health promotion sector, which currently has very little engagement in domestic violence as a public health issue. Domestic violence is generally perceived as a social service agency and/or police issue - yet it has death, injury, physical illness and mental distress rates that exceed some of the other issues currently considered priorities for public health service intervention. Recommendations conclude the chapter.

Discussion

While there were variations and exceptions among the three groups of people interviewed, the themes, across groups, were homogenous and clear.

This research found that domestic violence drives women 'crazy' and that, currently, there is very little understanding and therefore no appropriate response to this phenomenon. One of the major themes to emerge from this research was that when a person constantly has their perceptions denied, they lose their sense of groundedness and reality, and find it increasingly difficult to trust their own perceptions of events. People who are experiencing this phenomena, with or without the extra trauma of physical and sexual abuse, may exhibit behaviours that can be read as symptoms of mental illness. These

behaviours are, however, usually reasonable responses to living in intolerable situations. Women in these circumstances require safety and constructive support in order to recover - not a diagnosis of mental illness.

Information from the literature, and this study, supports the inference that there is a group of women - most of whom will remain unidentified - who are not only abused by their partners, but are also experiencing severe mental distress. This mental distress is:

- compounding these women's difficulty accessing help
- used by abusive partners to further abuse women
- preventing services responding appropriately to women who are attempting to access help.

These same experiences are further exacerbating the mental distress the women experience - and so a vicious cycle is set up.

Some of these women are currently using mental health services, but have not been identified as living in abusive relationships. Others have sought help and relief from a number of agencies including General Practice doctors. Again, most of these women will not have had abuse identified and therefore have not been offered appropriate help.

The participants in the interviews identified a wide range of behaviours that can be outcomes of abuse. For the women living with domestic violence, the symptoms they experience, and the response to the symptoms by others, become confirmation that the labels attached to them by themselves or others, i.e. crazy and stupid, are correct. Other people, observing the behaviours, but having no idea what is causing them, can think that the women are mentally ill.

Women who are seen as crazy or mentally ill find it even more difficult than other women in abusive relationships to access the help and support needed to escape. This means, in practice, that there are a number of women who may never be able to extricate themselves from abusive situations, because the services and the community offer no support and help or actively collude with the abuser to prevent them leaving. For example, a church that tells a woman her place is with her husband; a psychiatric institution that releases a woman back into the 'care' of the abuser; or a GP who prescribes a woman anti-depressants rather than acknowledging the reality of the abuse she has disclosed, are complicit in the abuse.

Because of the stigma and discrimination associated with mental illness, women who are already perceived to be mentally ill/crazy/mad will frequently find that their testimonies about abuse are given less credence than those of other women, or that they are not believed at all - while the abuser is believed. This situation adds stress to an already abusive and intolerable situation, and further endangers the mental and physical health of the women concerned.

Currently women are perceived to be in only two states. That is, either not having a mental illness, or being in a diagnosable state - and hence requiring a diagnosis and treatment. Giving a woman a diagnosis of mental illness, however, reinforces the idea that she is imagining the abuse that she is experiencing - or that in some way it is her fault because she is mentally ill.

What abused women really need is not a diagnosis, but the time, safety and support to reconnect with themselves and to regain faith in their own perceptions of reality. This requires specialist refuge services that can cater both for women's need for sanctuary and their need for abatement of symptoms. Specialist refuge services, that are responsive to the needs of abused women, are not currently provided by either the women's refuge or the mental health services. It also requires that the staff in any service a woman first accesses have the knowledge, skills and networks to assess her, screen for domestic violence and refer to the appropriate agencies.

What women want

From the results of the research and the extrapolated themes, a list can be drawn up of what women, who feel that domestic violence has driven them mad, really want.
These are:

Sleep

Many abused women are exhausted by their efforts to keep their lives going, care for their children, preserve appearances and cope with abuse. An important start to identifying and responding to the abusive situations they are in is to have some time to safely rest and recuperate. In order for women to really relax, they need to know that their children are safe and happy, so all services need to make provision for the care of children.

To be asked, specifically and comprehensively, about abuse

Asking general questions such as "how is your relationship" or questions relating only to physical abuse will not elicit adequate - if any - information about abusive situations. Asking specific questions helps women to identify and 'language' the domestic violence that they are, (or have been), living with and begin to articulate their experiences. Using tools such as the Duluth Power and Control Wheel (Domestic Abuse Intervention Project 1997) helps this process, as the model gives a graphic representation of domestic violence. It does not lead to 'false memory syndrome' as women will tell you what is and is not relevant to their circumstances.

As a number of commentators have identified, *"...spontaneous disclosure of abuse is unlikely ... therefore the responsibility for abuse identification frequently lies with the clinician"* (Young, Read et al. 2000) page 6. Most of the women spoken to in the current research felt that they wanted to have been asked very specifically about abuse and even then were unsure if they would have initially disclosed.

To be heard and believed

Because the stories these woman tell are so horrendous - or so far removed from accepted relationship parameters - it is easy to think that women are making up or exaggerating their stories. What they are usually doing, however, is minimising the abuse that they have experienced.

Information and language to describe their experiences and to make an informed choice

Only one of the women in the study had ever seen the Power and Control Wheel. (Domestic Abuse Intervention Project 1997) She was shown it by someone connected to a domestic violence service. None of the women had been given information about power and control or domestic violence by mental health service staff or the counselling services they had accessed. All of the women, when shown the power and control model, related to it and identified aspects of their own abuse from it.

Women want to understand the dynamics of abusive behaviour. They want to know that they are not to blame and that abuse happens to other people - and that patterns can be identified. They also want to know what their options are and to be supported in carrying out their choices.

This requires barriers between areas of influence and expertise to be broken down so that whatever service a woman accesses, she is given the tools to identify her situation and the options available to her to alleviate her situation. As this research identifies, distress caused by domestic violence is not the

sole domain of either domestic violence or mental health services, but of both - and all the other related agencies.

To be safe - to be offered and encouraged to use appropriate support services.

Even when abused women identify their experiences as abuse, many of them do not believe that they can access traditional domestic violence services. This may be because:

• they think the services are only for women who have been physically abused
• they might have misconceptions about the services
• they may not be aware of them.

It is also possible that the services currently available may not be suitable or safe for women who are manifesting signs of mental distress, as the staff may be insufficiently resourced to understand and provide suitable services.

Therefore, if mainstream services are not accessible to women, provision needs to be made to provide alternative, appropriate services.

Time to think and reflect

One other thing - one that will hopefully arise as a result of supplying the above conditions for women - is to give women the time and space for reflective thought. While women are in a state of fear and/or exhaustion, when they have no language to describe their circumstances, when the people they access for support and help are themselves condoning or replicating abusive behaviour, women have no opportunity to reflect on their situations and to begin to make informed decisions - or indeed any decisions - about how to respond.

This reinforces the necessity of giving women the words and tools with which to name the abuse they are experiencing. Without this, they are unable to clearly name and understand their situation and then make decisions about appropriate actions to alleviate the situation and to re-discover their own voice and power.

All of the components that women identify as necessary to begin healing, emphasise the importance of health and social service agency staff understanding the relationship between domestic violence and mental illness - or the manifesting of mental illness symptoms. This research has demonstrated how easy it is for abused women to appear less than credible in their presentation to health and other

professionals. Currently there are a number of government initiatives underway to strengthen the response to domestic violence and to put stronger processes in place to prevent abuse. These measures require an equal understanding of the psychological effects of domestic violence and the stigma attached to being perceived as "crazy".

Responses by services

Mental health service response

One thing re-emphasised in this research was the tendency of mental health service staff to work only with the symptoms that people present with (and the immediate alleviation of those symptoms), rather than looking behind the symptoms to gain an understanding of causation. This was highlighted by the comment about "someone "*hearing voices ... in the art class"* (C2) and how this needed to be dealt with as the presenting issue, rather than enquiring about why it may be happening.

This study has demonstrated that it may be critical to enquire about why symptoms are occurring, as the situation, if it is related to abuse, is unlikely to be relieved until causation is established and responded to. If, for example, a woman is hearing her abusive partner's voice in her head, her paranoia is a result of his constant monitoring of her or her belief that he will kill her or, her suicide attempts are a response to her feelings of being unable to get away from her situation, then she will not be able to stop these behaviours until the situation is changed. Medicating her, giving her electric shock therapy or subjecting her to psychiatric assessment and therapy, will not alleviate her situation but may, in fact, make it much worse. It can make her unable to protect herself, make her think that her fears and knowledge of her partner's dangerousness are a fabrication of her madness, make her reactions slow because of medication and give her partner more power over her. All of these things can result in abuse escalating.

All but one of the respondents felt that mental health services are not currently providing appropriate and constructive services to women experiencing domestic violence. They felt that people who worked in mental health service should be able to recognise abuse, help women develop safety plans, and have better relationships with other services to enable them to refer on appropriately. They also identified a need for the development of specialist refuge services that could work specifically with 'duel diagnosis' women - abused women with mental illness or drug and alcohol problems.

The literature states that people in mental health services often feel that it would be inappropriate to screen for abuse at the time of a women's first admission to a psychiatric service. Two reasons were given for this. The first was that too much else is going on at the time of first admission. The other, that women might become distressed (or more distressed) if the issue of abuse was raised. Discussions with the mental health professionals interviewed during the research confirm these findings. Not because they necessarily believed this themselves, but that they believed that this what their peers thought. This suggests that the people who do not ask have never discussed with women whether or not they want to be asked about domestic violence and childhood abuse, but instead, are making assumptions based on their own discomfort and lack of knowledge of the issue.

When told of this response from mental health service staff, the women who had experienced abuse laughed. They countered by explaining that most women would be relieved to be asked about their circumstances and why they were presenting at a psychiatric service as, for many of them, it would be the first time some one had asked, and listened to what they had to say, about their situation.

Studies carried out in New Zealand by John Read (Read and Fraser 1998; Read and Fraser 1998) (Agar and Read 2000; Lothian and Read 2000) (Young, Read et al. 2000) and John Coverdale (Coverdale and Turbott 1999) about screening for childhood abuse showed that most people found screening appropriate - or at least, not more distressing than the other processes they are going through at admission to a mental health service.

Once domestic violence has been disclosed, respondents identified the need for specific interventions:
• to help women name what has been happening to them
• to re-establish their faith in themselves and their own perceptions of reality
• to take back control of their own lives.
They felt that, in order for these processes to happen, mental health service staff would need to be trained in how to view the world from a more community/holistic perspective - rather than the individual dysfunction model that they currently have.

Women require that the people in the services they interact with, when they try to leave an abusive situation, have an understanding of the severity and breadth of the symptomatic behaviours they will encounter when they work with abused women and will not pathologise these symptoms, but will see

them for what they are – as responses to abuse. What these women don't need is diagnosis and treatment for mental illness, as this does not address the reason the women are exhibiting the symptoms. As has been constantly noted throughout this thesis, mental health intervention can reinforce a woman's feelings of powerlessness and lack of control and leave her even more vulnerable to her partner's abuse.

This research suggests that mental health services need to be proactive - not only in identifying women who have been, or are being, abused, but also in the referring of these women to appropriate domestic violence services. This would include the following actions.

Screening.

All women who enter mental health services should be asked specific questions about abuse - both childhood and past and current domestic violence - at the time of first assessment/admission. Respondents in this research indicated that this early identification is very important to them.

This process of screening for abuse should be repeated each time a woman accesses mental health services and if subsequent behaviours or comments suggest that a woman might have abuse issues that have not previously been identified - as many women will take some time to develop enough trust to disclose.

It is also important that men be screened and referred to appropriate services if abusive behaviour is suspected. If it is suspected that men are abusive, their partners should be given information about domestic violence and available services.

As men and women will almost always minimise abuse, it is important to act on any disclosure, no matter how minor.

Safety

If current domestic violence is identified, the staff's first priority should be to work with the women to devise a safety plan that aims to minimise further harm.

Referral

If a woman indicates that she has been, or is currently, in an abusive relationship she should immediately be given information about domestic violence. This information should include the effects that domestic violence can have on long term mental health. Also, a referral should be made to the appropriate services. This would be specialist domestic violence/mental illness services, if they are available, or domestic violence agencies trained to work with mentally distressed women (if specialist services are not available).

Choice

It is important that women be supported in whatever decisions they make in response to the information and referrals they receive. Some women feel that agencies give information then become frustrated when women don't respond as the agency wants them to - and so withdraw support. Part of the process of women regaining control of their lives is regaining agency, i.e., the ability to make decisions, and even make mistakes, without interference and censure from others.

Co-operation

Thereafter, all ongoing care and treatment needs to be carried out in a three-way consultation between the mental health service, the domestic violence or sexual abuse agency and the woman herself. This is to ensure that the agencies are not re-abusing women by withholding decision-making and other power from them. It also ensures that women are not put at increased risk by the actions of the services working with them.

Training Needs

For mandatory screening, safety, referral, choice and co-operation to occur it would require:

• The compulsory training of all mental health service staff in the dynamics and mental health consequences of domestic violence and appropriate referral procedures.

• The training of domestic violence and sexual abuse agency staff about the mental health consequences of domestic violence and how to manage these consequences within their services.

The ideal scenario would be effective inter-agency training and networking and the development of specialist services for women who have been so affected and/or damaged by domestic violence that existing refuge services are not sufficient to meet their needs.

Public Health Service Response

Being driven mad by domestic violence is an issue that affects a sizeable population of women and their families and friends. As previously noted, Nickolaos Kazantzis (Kazantzis, Flett et al. 2000) identified that domestic violence may account for as much as 12% of psychological distress and 7% of physical illness - not injury, among adult women in New Zealand. Also, as documented in Chapter 1, there are high rates of injury, alcohol and drug abuse, pregnancy complications and suicide associated with domestic violence. Between 50% - 60% of murders committed in New Zealand each year are men murdering their partners.

Abuse that causes 12% of psychological distress, 7% of physical illness, at least half the murders and high rates of injury is a major public health problem.

Also, as noted in the Introduction, if women are 'driven crazy' by abuse, it is not only the women themselves who suffer the effects and the consequences, but also everyone involved with them - especially their children. These women cross cultures and socio-economic groupings, and are, apart from the costs to themselves, costing the country millions of dollars in inappropriate care, lost opportunities and sometimes, lost life. Approaching the problem as an individual treatment issue denies the far reaching effects of domestic violence and the societal structures that work to keep abuse, and abused women, invisible and/or blamed for their abuse.

This important public health issue demands a constructive action from the public health community, on all levels, if positive change is to occur. In order to achieve the maximum benefit from intervention, a health promotion approach could be used that would include the following elements, based on the Ottawa Charter action points. (World Health Organisation 1986)

Policy development

In order for mental health services (and others) to make the changes necessary to alter their practice, policies and procedures about screening for domestic violence and responding to it must be developed. Currently, guidelines for intervention polices and procedures for health services are being developed for the MOH. (Fanslow 2001) If these standards are to be adopted by mental health services it may be necessary for the Mental Health Commission to also support their introduction and for training about the protocols to be delivered.

As part of this policy development and implementation, all levels of the health service will need to develop relationships and understandings with domestic violence and sexual abuse organisations. Public health practitioners can provide support and help in all of these processes.

Other agencies that work with women who experience domestic violence will also need to develop policies and protocols around how they screen and identify abuse and respond to women who disclose - i.e. Barnardo's, Plunket, health services, Play Centre etc. Public health practitioners can, again, provide support and help in this process.

Also, public health practitioners need to be supporting specific domestic violence legislation and the ongoing education of the services that enforce it - i.e., the Police, lawyers and the family and criminal courts.

Janet Fanslow's guidelines (Fanslow 2001), and the national guidelines from the Ministry of Health, 'Family Violence - Guidelines for Health Sector Providers to Develop Practice Protocols' (Ministry of Health 1998) provide the basis for the policy development identified above.

Reorienting Health and Other Services.

Currently, with the mental health service's focus on symptoms and not causality, clients are unlikely to be screened for domestic violence and to have their admissions of abuse effectively acted upon. Therefore, a culture change is required within the mental health services in order to enable this to happen. There also needs to be a change in thinking about the reliability of women who seek help for mental health problems, to ensure that they are acknowledged as credible witnesses to their own stories.

The work that has been started with other health professionals - especially General Practice doctors and emergency services to develop training and protocols, needs to be extended to mental health services and consolidated as core practice.

Training and policy development needs to occur with associated services, especially lawyers, domestic violence services, police, CYFS, court staff and judges and people who work in physical health care

services, to break down the misconceptions about domestic violence and women who develop mental health problems from the abuse they have experienced.

Public health staff can be involved in the education and support of their mental health service and other colleagues, to provide a community/holistic perspective and to help them make the necessary changes in practice and processes.

Developing Supportive Environments

An important part of promoting non-violent interventions is to look broadly at all the social interactions that support and encourage violence. Competitive sports, competitive business behaviour, interactions that are hierarchical rather than equitable, a privileging of male-specific thought and paradigms as inherently better or more sound than women's - all of these things encourage abuse of power. Nonviolent behaviour change is not so much an individual change issue as a distinct paradigm shift to a more equitable, non-abusive society. This will require an in-depth look at how we socialise boys and girls, and men and women, in our community – and what we need to do differently.

More specifically, there need to be specialist services, such as refuges, for women who feel that they have been driven mad by abuse - especially those who are currently unable to access services. These services require staff with the experience to work across disciplines to ensure that their clients are getting the most appropriate support.

Developing Personal Skills

Although this research has focused on the experiences of women, prevention work must concentrate on men and boys.

This involves two streams of work. One is working alongside the groups that are running programmes for offenders, to help them develop and deliver effective behaviour change programmes using public health knowledge and expertise.

The other, is individual skill development with young men and boys, to prevent abusive behaviours from developing. This involves working with schools, anger management and other agencies, to help boys and young men identify potentially abusive behaviours and learn other ways of responding.

It also involves promoting an understanding of healthy and unhealthy, abusive and non-abusive relationships, among young people. This could be achieved by sexuality education and healthy schools programmes incorporating this information into their syllabuses. This would provide the added benefit of giving girls the skills to identify a potentially abusive situation and to extricate themselves from it before they become trapped. This work could happen over a number of years - from primary school onwards, thereby normalising some of the concepts, rather than highlighting them.

Training is required for staff at all levels of the mental health services, domestic violence services and related agencies such as the courts, police and counselors, to teach them about the mental health effects of domestic violence and how to effectively work with women who are, or have been, abused and driven mad. Public health/health education skills and experience can be utilised to help agencies design effective training programmes based on proven behaviour change theories.

Strengthening Communities

This involves the work already started by others to encourage communities who are not accepting of violence and abuse, and who actively and vocally work to identify and prevent it.

Public health services do very little work on gender specific issues, other than that currently done by Auckland public health services. I feel that we need to start addressing these issues instead of leaving them to social service and police agencies. This should be a core component of public health work - especially looking at working with men to prevent abuse, rather than constantly focusing on women as the recipients of it.

One of the things that prevents changes being made to the way we perceive and resist domestic violence is the way that it is discussed in our society. Currently, when a man commits an act of violence (that becomes public knowledge) he is talked about as being 'an animal', as if this was not usual 'human' behaviour. Until we admit that violence and abuse are mainstream, world-wide, socialised male characteristics - that, fortunately, some men have the strength to overcome - we will not be able to address and change the level of mental, physical, emotional and spiritual abuse in our communities.

Domestic violence is not a problem that will go away if left alone. Changes will require a nation-wide shift in thinking about the primacy and privileges of the nuclear family, and the roles of men and

women within relationships. Until we, as a society, or maybe as human beings, truly believe in men and women having equal rights in relationships - that violence and abuse are unacceptable within adult relationships - (and adult/child relationships) and that 'power over' is not an acceptable way of getting one's needs met, we will not prevent domestic violence and the damage that it causes.

Where to from here?

Research, knowledge and skills

Several things need to happen next. One is to continue to research the relationship between mental illness and domestic violence to ensure that the research will be perceived as robust and methodologically sound. Another is to begin to formulate how this information, and the knowledge and skills already available in the various services about this issue, can be translated into action. This needs to happen to ensure that the women who are currently being abused and marginalised by the various services and systems they access can, in the future, receive the help and support that they need to become well and independent.

This research has highlighted the vast amount of knowledge that some of the women working in diverse services have about the abused clients whom they work with. It also demonstrates how undervalued their knowledge is, as it is not incorporated into any training, strategising or reorientation of services. These women, who have an awareness of domestic violence, often seem to have gained it through their personal circumstances or a feminist perspective on the world. Very few have received it via training. These women could, immediately, be utilised as resource people, to train and support others in the development of domestic violence policies and procedures within their own services.

Services

Specific refuge services are needed for women who feel that they have been driven mad by domestic violence. These services would require staff, available 24 hours a day, who have duel training in mental illness and domestic violence or drug and alcohol addiction and domestic violence. These services could be regional services for women unable to access mainstream refuges because of assumed mental illness or drug and alcohol addiction. Responsibility for funding such a service would sit jointly with the mental health team at the MOH and CYFS.

National Campaign

We need a nation-wide campaign to:

• reduce the incidence of domestic violence

• inform people about the dynamics of abuse

• begin to challenge current socialisation and gender stereotypes

• reduce tolerance for violence.

This could be based on a similar structure to that of the "Like Minds" campaign, which counters stigma and discrimination associated with mental illness. This is a nation-wide public health campaign that has both a national and regional provider structure. The national portion of the campaign organises national media campaigns, oversees the work of a PR company who produce national resources, and addresses issues of policy and national significance. It also oversees the direction of the regional campaigns. Within regions, organisations are contracted to provide community services such as workshops, awareness raising, policy development and media events. Each region has Maori, Pacific and mainstream providers, all of whom work under the "Like Minds" kaupapa - while bringing their individual skills and flavour to their work. This national campaign, that has a big evaluation component, has already succeeded in raising awareness and starting to change attitudes and behaviour.

Recommendations

Mental Health services

• All mental health service staff to be trained in:

- the effects of domestic violence
- the possible mental health effects of domestic violence
- the dynamics of domestic violence
- the mental health related manifestations of abuse
- how to respond to disclosures of abuse

• All women to be comprehensively screened for domestic violence whenever they enter a mental health service

• When domestic violence is confirmed or suspected a woman's safety is to be given priority over treatment

• When domestic violence is identified, women to be referred immediately to appropriate domestic violence agencies

• All women, for whom abuse is suspected, to be given information about domestic violence.

Public Health Services.

• Public Health services be directed to take a proactive approach to gender and domestic violence specific education and campaigns.

• A national campaign be developed, based on the "Like Minds" campaign.

• Interventions be developed for school sexuality and 'Healthy Schools' programmes to educate young people about healthy and unhealthy relationships

Campaigns developed that focus on the socialisation of boys and girls, specifically designed to promote equality and non-abusive relationships.

General.

• Develop specific regional services that provide refuge and support for women who cannot access other refuge services because of perceived mental illness or drug and alcohol problems.

• Staff at all agencies who interact with abused women be included in training about domestic violence, the relationship between mental illness and domestic violence, and how to respond appropriately to women who present at their service.

• Research be carried out to further inform this issue.

• Eliminate all forms of discrimination against women in employment, finance, housing and provision of services.

• Support international conventions for the equal status of women and protection of women and children.

Conclusion

All of the women who participated in this research have shown great courage and strength, in living with and recovering from the abuse that they have experienced. I have shown how their experiences of domestic violence have made them doubt their own sanity, and how they have emerged from their relationships with an understanding that it was their partners who caused them to feel this way. Often the actions and attitudes of those they went to for help reinforced their feelings of being crazy.

The research has identified a number of strategies that would help women who feel that domestic violence has driven them mad. These include training of professionals, appropriate, specific refuge

services, screening by mental health services, a national campaign and more understanding of, and discussion about, the issues.

Domestic violence is a world-wide phenomena, directly related to male privilege and the position of women in society. It is not an individual problem that can be fixed by working one-on-one with offenders. This highlights the need for comprehensive structural and paradigm changes - changes which can only be managed through policy and comprehensive long-term education processes.

This research has looked at one aspect of domestic violence. Addressing this relatively unknown and unexplored issue of women being driven crazy by their abusive partners, will help a large number of women recover from the trauma that they are experiencing in their relationships. Suggestions have been made as to how mental health services could respond to this issue. However, without addressing the broad problem of why domestic violence exists, and is so prevalent in our society, we will always just be reacting and the problem will continue. Therefore this research proposes that a holistic programme be adopted, to examine and eliminate the causes of domestic violence in our communities.

Appendices

Appendix One
CONSENT FORM

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF TEN YEARS

"He drove me mad" The relationship between mental illness and domestic violence.

Researcher: Debbie Hager.

I have read and understood the information sheet dated July 2000 for volunteers taking part in this research project. I have had an opportunity to ask questions and have them answered and I am satisfied with the answers and that I understand the research.

I understand that:

• taking part in this research is voluntary (my choice) and that I can withdraw at any time and that this will in no way affect my on-going or future health care.

• all information I provide in an interview is confidential and my name and identifying details will not be used when the results of the interviews are written up or in any material that results from the study.

• I can withdraw the information that I have provided up to three months after the interview.

• the interview will be stopped at any time if I request it.

• I can bring a friend or support person with me to the interview.

I have had time to consider whether to take part. Yes/No

I know who to contact if I require support or information after the interview. Yes/No

I agree to take part in this research. Yes/No

I agree to the interview being audio taped Yes/No

I want to receive a copy of the final report Yes/No

Note. This will not be available until Oct/Nov 2001.

I want a copy of my interview on audio tape. - Yes/No

I.....—(full name)

Hereby consent to take part in this study.

Signed: **Signature** of Witness:

Date: Name of Witness:

Project explained by Debbie Hager.

Debbie Hager Signature:

Researcher. Date:

Contact:

Framework Trust, PO Box 52 164, Kingsland**.**

Phone 849 6985.

My supervisor is: Dr Jennifer Hand

Department of Community Health

The University of Auckland

Private Bag 92019

Auckland. Tel. 373-7999 extn. 7645

The Head of Department is: Professor Rod Jackson

Department of Community Health

The University of Auckland

Private Bag 92019

Auckland. Tel. 3737-999 extn 6343

If you have any concerns about your rights you can contact the Health Advocates Trust Tel no. 0800 205 555 - Northland to Franklin

Appendix Two

Advertisement.

He drove me mad - the relationship between domestic violence and mental illness.

Kia Ora

Do you think that abuse from a male partner led to your mental illness - or feelings of being 'crazy'?

My name is Debbie Hager. I am writing a thesis about the connections between domestic abuse and mental illness and I want to interview women about their experiences. All information that I collect will be confidential. No one will be able to identify you.

The research is not about illness that is the result of childhood abuse.

The aim of the research is to make recommendations about how mental health services for abused women could be improved.

If you want to be interviewed or would like to ask me questions or talk about what I am doing please let me know by phoning me on **849 6985** during the day. If I am not available please leave me a message with your name and phone number so I can get back to you. If I need to ring you back I will not give anyone else information about why I am ringing.

Thank you for your help. I look forward to talking to you.

Debbie Hager.

Appendix Three

PARTICIPANT INFORMATION SHEET

"He drove me mad" The relationship between mental illness and domestic violence.

Kia Ora.

My name is Debbie Hager. I am a student at the University of Auckland enrolled for my Masters in Public Health in the Department of Community Health. I am conducting research for the purpose of my thesis on the relationship between domestic violence and mental illness and have chosen this field because of the experiences of women that I have worked with who believe that their mental illness is a result of the abuse that they have experienced. The aim of the research is to make recommendations about how mental health services for abused women could be improved.

You are invited to participate in my research. As part of my research I want to interview women who think that their diagnosed or undiagnosed mental illness is a consequence of having lived in a physically or mentally abusive relationship with a male partner. This research is not about illness that is a result of childhood abuse. Please think about whether or not you would like to participate in the research and contact me if you would like to be interviewed. I would like to conduct the interviews between October 2000 and March 2001.

Interviews will take about an hour to an hour and a half and will be at a time and place chosen by you. I would like to audio tape the interview but this would only be done with your consent and the tape can be turned off at any time. After the initial interview I may want to contact you again just to clarify information you have given me.

During the interview you do not have to answer all the questions and you can stop the interview at any time. Once the interview has occurred you can withdraw your information up to three months after the interview if you change your mind about participating.

All the information that you provide in an interview is confidential and your name and identifying details will not be used when the results of the interviews are written up or in any subsequent reporting of the information. No one will be told that you have participated in the interview unless you request it. You can however bring a friend or a support person if you want to.

There is a possibility that discussing your experiences may be upsetting. If, after the interview, you feel that you would like support and/or counselling about the issues that have been raised I have organised for culturally appropriate professional services to be available for you.

If you want to be interviewed please let me know by phoning me on 849 6985 during the day. If I am not available please leave me a message with your name and phone number so I can get back to you. If I need to ring you back I will not give anyone else information about why I am ringing.

Please note that:

• taking part in this study is voluntary (your choice) and that you can withdraw at any time and that this will in no way affect your on-going or future health care.

• all information you provide in an interview is confidential. No material, which could personally identify you, will be used in any reports on this study.

• the interview will be stopped if you don't want to continue**.**

• you can bring a friend or a support person if you want to.

• provision has been made for you to receive ongoing support if required after the interview.

• you can withdraw your information up to three months after the interview.

This study has received ethical approval from the Auckland Ethics Committee.

If you have any concerns about your rights you can also contact the Health Advocates Trust Tel no. 0800 205 555 - Northland to Franklin.

Thank you very much for your time and help in making this study possible. If you have any questions or wish to know more please phone me at work or write to me.

Debbie Hager
Framework Trust,
PO Box 52 164
Kingsland Tel. 849 6985

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The University of Auckland
Private Bag 92019
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DECLARATION A.Trials:
Compensation

In the unlikely event of a physical injury as a result of your participation in this study, you will be covered by the accident compensation legislation with its limitations. If you have any questions about ACC please feel free to ask the researcher for more information before you agree to take part in this trial. If you suffer mental injury only as a result of your participation in this research, you will not be eligible for ACC compensation and you should urgently obtain legal advice regarding your rights.

Appendix Four

PROFESSIONAL PARTICIPANT INFORMATION SHEET

"He drove me mad" The relationship between mental illness and domestic violence.

Kia Ora

My name is Debbie Hager. I am a student at the University of Auckland enrolled for my Masters in Public Health in the Department of Community Health. I am conducting research for the purpose of my thesis on the relationship between domestic violence and mental illness and have chosen this field because of the experiences of women that I have worked with who believe that their mental illness is a result of the abuse that they have experienced. T his study is being conducted with the aim to make recommendations about how mental health services for abused women could be improved.

You are invited to participate in my research. As part of my research I want to interview a range of mental health, domestic violence and related professionals to elicit a professional understanding/opinion about the relationship between the abuse a woman has suffered in a domestic adult relationship and a subsequent diagnosis of mental illness and to explore what needs to happen to enable mental health services to respond to any apparent relationship between domestic abuse and mental illness. This research is not about illness that is a result of childhood abuse.

Please think about whether or not you would like to participate in the research and contact me when you have made your decision- I would like to conduct the interviews between October 2000 and March 2001.

Interviews will take about three-quarters of an hour to an hour and will be at a time and place chosen by you. I would like to audio tape the interview but this would only be done with your consent and the tape can he turned off at any time**.** After the initial interview I may want to contact you again just to clarify information you have given me.

During the interview you do not have to answer all the questions and you can stop the interview at any time. Once the interview has occurred you can withdraw your information up to three months after the interviews if you change your mind about participating. All the information that you provide in an interview is confidential and your name and identifying details will not be used when the results of the interviews are written up. No one will be told that you have participated in the interview unless you request it.

If you want to be interviewed please let me know by phoning me on 849 6985 during the day. If I am not available please leave me a message with your name and phone number so I can get back to you. If I need to ring you back I will not give anyone else information about why I am ringing.

Please note that:

• taking part in this study is voluntary (your choice) and that you can withdraw at any time and that this will in no way affect your on-going or future health care.

• all information you provide in an interview is confidential and your name and identifying details will not be used when the results of the interviews are written up.

• the interview will be stopped if you don't want to continue.

• You can withdraw your information up to three months after the interview.

This study has received ethical approval from the Auckland Ethics Committee.

Thank you very much for your time and help in making this study possible. If you have any questions or wish to know more please phone me at work or write to me.

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Appendix Five

Professionals Interview schedule

1. Tell me what your Job is.
1. How much contact do you have with women in your job?
1. Tell me what you think domestic violence is - how would you define it to someone who doesn't know what it is?
1. Tell me what you think mental illness is - how would you define it to someone who doesn't know what it is?
1. What, if any, long term effects does domestic violence have on someone who experiences it?
1. Are these responses signs of mental illness - what do you mean by that?
1. What do you think the relationship is between domestic violence and mental illness in women?
1. What could mental health services do to address this?
1. How could these changes be made?
1. What would need to happen for the services to change/respond?
1. What else do I need to know?
1. What else do you want to say?

Appendix Six

Women who have experienced abuse.

Interview Schedule

- Tell me a bit about yourself- do you work, care for children, participate in any music or arts....? Where do you come from, have you always lived in Auckland? What makes you interested in this study?

- Before we carry on with the interview there are some questions that I need to ask you.

- The sorts of women that I want to talk to are women who haven't been abused as children either physically mentally or emotionally. Does this fit with your experience?

- I also need to talk to people who didn't have a history of mental illness before their abuse ..is this you?

    - Have you been:

- • abused by a stranger, i.e. a person you did not have a familial relationship with Yes/No
- • abused by a family member who was not your partner. Yes/No

<u>For women who fit the criteria.</u>

- Tell. me what you think domestic violence is - how would you define it to someone who doesn't know what it is?

- Tell me what you think mental illness is - how would you define it to someone who doesn't know what it is?

- Have you ever said or done things that you have felt are signs of a mental illness?
- Have you ever said or done things that someone else has said are signs of a mental illness?
- Do you think that the way you were feeling was mental illness?
- • if not, what is it?
- What do you think caused you to experience these symptoms?
- Tell me about the sort of abuse that you experienced.
- 1, Did you tell anyone about it?
- What did they say?
- Have you had any contact with mental health services?
- Did they ask about the abuse?
- Did you tell them about the abuse?
- How did they react when you told them?
- How did you feel about their reaction?
- Was it useful to you?
- What would you have wanted to happen?
- What would need to happen for the services to change/respond?

- What else do I need to know?

- What else do you want to say?

- How are you feeling? Are you feeling all right or do you want the name of a
- contact person in case you need support or counseling after talking about these
- things?

<u>For women who don't fit the criteria</u>.

- Tell me what you think domestic violence is - how would you define it to
- someone who doesn't know what it is?

- Tell me what you think mental illness is - how would you define it to someone
- who doesn't know what it is?

- What, if any, long term effects does domestic violence have on someone who
- experiences it?

- Are these responses signs of mental illness - what do you mean by that?
    - What do you think the relationship is between domestic violence and mental
- illness in women?

- What could mental health services do to address this?

- What would need to happen for the services to change/respond?

- What else do I need to know?

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