

Editorial

Domestic violence: the hidden epidemic associated with mental illness†

Kelsey Hegarty

**Summary**

Despite domestic violence being a very common problem in individuals with severe mental illness, there is very little research in this setting. Multiple barriers exist to disclosure by users and enquiry by providers. Training and systems for identification and responding to

domestic violence are urgently needed in mental health clinics.

Declaration of interest

None.

Kelsey Hegarty is a general practitioner and Associate Professor who leads an abuse and violence research programme in primary care at the University of Melbourne.

Domestic violence is a common hidden problem for women attending clinical practice¹ and is a major cause of mental ill health globally.² Domestic violence is defined by the World Health Organization (WHO) as any behaviour within an intimate relationship that causes physical, psychological or sexual harm.³ Such behaviour includes acts of physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion, and various controlling behaviours, for example isolating from family and friends, monitoring movements and deprivation of basic necessities. The WHO multicountry study on women's health estimated that 15–71% of women had ever been physically or sexually assaulted by partners.³ Domestic violence is the leading cause of morbidity and mortality for women of childbearing age,⁴ with the main contribution being from the mental health consequences of abuse.⁵ Domestic violence has an inter-generational effect with children witnessing abuse having multiple health problems.⁶ Men are less likely than women to be victims of combined physical, emotional and sexual abuse from their partners and thus have been researched to a less extent.¹

Mental health settings

Domestic violence is often not looked for in mental health settings, nor examined in research into mental health issues. Furthermore, there are many barriers to enquiry by health professionals⁷ and disclosure by patients.⁸ This lack of discussion in clinical settings has seen a movement, particularly in the USA, for screening of all women in clinical settings. This is despite there being no current evidence to support such a move.⁹ Currently, we do not know whether screening will cause more good than harm as we are unsure from evidence which interventions will help women disclosing domestic violence in clinical practice. We do know, however, that when individuals are presenting with mental health issues such as depression, anxiety, insomnia, suicidal ideation and post-traumatic stress disorder, it is very likely that women will have underlying abuse and violence issues.⁵ The association of domestic violence with more severe mental illness, for example bipolar disorder and schizophrenia, has been less

explored. From the limited studies,^{10,11} it would appear that the vast majority of people with severe mental illness have experienced either physical or sexual assault during their lifetime and this is often associated with a history of childhood abuse and substance misuse.

Service user and professionals views

In this issue of the *Journal*, Rose *et al*¹² explore for the first time both mental health service user and professional views on routine enquiry about domestic violence; and facilitators and barriers to disclosure from both user and professional perspectives. The main findings are that service users are reluctant to disclose domestic violence because of their fear about the potential consequences of such a disclosure. Mental health professionals report finding enquiry about domestic violence difficult because of their lack of knowledge and expertise in this area or because they do not think it is part of their role. Professionals express further barriers related to gender, with male professionals feeling that women may not disclose to them, and to cultural issues, with violence being more condoned in particular cultures. Facilitators to disclosure centred around the quality of the health professional–user relationship and included trust, listening, empathy.

Are these barriers realistic?

Research has shown that domestic violence victims are often judged, not believed and blamed by health professionals, so it is no wonder that victims are hesitant to bring up the violence.¹³ In the main, health professionals have not had specific undergraduate or postgraduate training on this issue,¹⁴ so it is no surprise that they feel ill-equipped to enquire about or respond to domestic violence. However, it is a sad reflection on the fields of psychiatry and other mental health professions that providers do not feel it is part of their role, when the association of abuse and violence and mental ill health is so strong. The over-reliance on medical, diagnostic and treatment models by mental health providers¹⁵ can result in social issues such as domestic violence being overlooked. Facilitators to disclosure essentially are good communication skills, regardless of the health professional's gender. Female survivors describe wanting primary care health providers to listen, show validation, empathy, and non-judgemental and confidential responses.¹³ These skills are all within the scope of experienced mental health professionals.

The paper in this journal also raises the issue of whether perpetration of violence by individuals who are mentally unwell

†See pp. 189–194, this issue.

is overstated, with many mental health providers assessing risk of perpetration of violence by clients but not experiences of violence.¹² In fact, mental health service users are more likely to be victims of violence rather than perpetrators.¹⁰ However, people who are victimised by physical abuse throughout their lives (not just in childhood) are more likely to use violence on others. Psychiatry, throughout history, has focused on perpetration of violence by people who are mentally unwell and the experience of childhood abuse, rather than the experience of adult abuse. It may be that the health professionals find it difficult to tolerate the pain and helplessness they feel when individuals talk about their experiences of recent abuse or when their own traumatic experiences are evoked.¹⁶ The mental health professions need to overcome this blind spot, as mental health clinics are a site where routine enquiry and simple intervention¹⁷ may benefit people who have severe mental illness as a result of domestic violence.

What are potential solutions?

Little current evidence guides us for responding to victims of domestic violence who also have a severe mental illness, as it is not included frequently as a measure in studies. The responses showing most promise from general health settings for women who have been abused are advocacy, empowerment and safety-based interventions delivered by nurses or para-professionals. Psychological therapies such as cognitive-behavioural therapy, both group and individual, delivered by psychologists also show improvement in depression for women who have experienced domestic violence.⁹ Both advocacy and psychological therapies could be offered to people with the dual diagnosis of domestic violence and severe mental health, while more evidence is gathered from the mental healthcare setting. There is an urgent need for training of mental health professionals with systems implemented to support them to respond to this serious public health problem and to see this issue as part of their role.

Kelsey Hegarty, MBBS, DipRACOG, FRACGP, PhD, Primary Care Research Unit, Department of General Practice, University of Melbourne, 200 Berkeley Street, Melbourne 3068, Australia. Email: k.hegarty@unimelb.edu.au

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