TOJCE
ISSN: 2146-8192 The Online Journal of Counseling and Education, 2015, 4(2), 1-13

Domestic Violence and Trauma:

Diagnostic Implications for Mental Health Professionals

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Abstract

The impact of traumatic stress, especially when the trauma is caused by an intimate partner is devastating for the victim. Trauma-related symptoms often include increased startle response, nightmares, intrusive images, emotional numbness, difficulty sleeping, increased irritability, and difficulty with concentration, which are characteristic of PTSD. Additional symptoms include depression, anxiety, alcohol and drug abuse problems, and alterations in belief systems, such as feelings of trust, safety, worthiness, connection with others and sense of control over one's life (The International Society for Traumatic Stress Studies, 2003, online). This research study examined 235 licensed mental health professionals' working clinical knowledge of domestic violence as well as whether or not they are identifying the symptoms of PTSD when assessing, diagnosing, and treating victims of domestic violence.

Keywords: mental health professionals, trauma, domestic violence, victimization, traumatic stress, intimate partner trauma

Although scholarly research has recognized the critical clinical link between domestic violence and PTSD, the research also suggests that many practitioners have not. If licensed mental health professionals are not properly diagnosing victims of domestic violence because they are unfamiliar with the symptoms of PTSD, they will overlook the PTSD and only treat more common clinical diagnosis' such as depression or anxiety (Hughes & Jones, 2000). The literature shows that most clinical treatment for victims of domestic violence includes strategies to improve safety and reduce the risk for future abuse, but does not target psychological symptoms (Warshaw, Maroney, & Barnes, 2003). Researchers (Cohn & Rudman, 2004 & Warshaw, 2002) have concluded that it is critically important for mental health practitioners to make the link between intimate partner violence and PTSD. Hughes' and Jones' (2000) study noted that treatment of victims of domestic violence can improve if they are properly diagnosed with PTSD. The treatment can focus on the traumatic symptoms as opposed to self-blame. Rodgers and Norman (2004, online) added that focusing treatment on the PTSD symptoms "can serve to reduce the victim's anxiety and sense of powerlessness."

The rationale for this study is that if mainstream licensed mental health professionals on a local level are missing the connection between domestic violence and PTSD when assessing, diagnosis, and/or treating victims of domestic violence, a need for education, training, and development of new assessment, diagnostic, and treatment tools should be developed and implemented (Cohn & Rudman, 2004). Improving the quality of mental health care is priority in the Untied States (Patel, Butler, & Wells, 2007). Assisting mental health professionals in making the link between the victimization and trauma of domestic violence and PTSD will benefit both the victims and the mental health professionals who treat them.

Research is lacking on the issue of licensed mental health professionals' assessment, diagnosis and/or treatment of victims of domestic violence as well as whether or not mental health professionals are making the critical link between domestic violence and PTSD when clinically appropriate. Rogers and Norman (2005) noted they were able to locate only one study conducted by Schlee, et al. (1998) that particularly addressed the impact of a PTSD diagnosis on the treatment outcomes of victims of domestic violence.

A Meta-Analysis Study of Domestic Violence and PTSD

In January, 2000, Hughes and Jones, published a 78-page study entitled "Women, Domestic Violence, and Posttraumatic Stress Disorder (PTSD)," According to the executive summary:

> the project had multiple objectives. The first was to compile and analyze data from professional literature that was based on studies of battered women to determine (a) the correlation of domestic violence and PTSD, (b) the best treatment strategies for PTSD, and (c) the evidence of PTSD treatment effectiveness with battered women. (p. 5)

The report identified and analyzed 42 studies on domestic violence and its correlation with PTSD that were published between 1987 and 1999 (Hughes and Jones, 2000, p. 13). The study's methodology utilized three means of data collection. The first method was Systematic Research Synthesis (SRS), a meta-analysis process used to analyze data collected from the academic literature combined with the integrative qualities of a traditional literature review (Hughes and Loring, 2000, p. 11). Simply described, "SRS is used to 'make sense' of massive and disorderly research evidence" (Hughes and Loring, 2000, p. 11). The second means used in Hughes' and Jones' study was utilization of on-line databases, and the third data collection method was a mailed, self-administered survey sent to 58 California County Mental Health Directors asking them to answer some of the project research questions. The study also described the four steps used in the SRS process (Hughes and Loring, 2000, p. 12-13).

The study then answered the research question, "What does the academic literature tell us about PTSD for women as a result of domestic violence against them?" by setting forth eight generalizations that represented the consensus findings and cited the supporting studies (Hughes & Jones, 2000, p.15-23). The eight generalized findings are summarized as follows (with citations omitted):

1. A substantial proportion of victimized women exhibit PTSD symptoms (31% to 84%) as currently defined by the *DSM-IV-TR*
2. Victimized women living in domestic violence shelters exhibit PTSD symptoms at a higher frequency (40% to 84%) than victimized women not living in shelters (p. 17).
3. The likelihood of PTSD and other types of psychiatric disorders are increased by multiple victimization experiences such as childhood abuse, especially sexual abuse, and adult sexual abuse (p. 17).

4. The intensity of PTSD is associated with the extent, severity, and type of abuse (sexual, severe physical, and psychological). The more life threatening the abuse is the more traumatic the impact. Although victims can experience PTSD without severe abuse, there is increased trauma when there is severe abuse (p. 17).

5. PTSD is typically accompanied by other forms of emotional distress and mental disorders, such as a high prevalence of depression and dysthymia (p. 18).

6. Domestic violence victims who exhibit PTSD symptoms are at risk of suicide which may represent a link between abuse and suicidal ideations (p. 18).

7. Victimized women had a higher percentage of substance abuse. Reports of child abuse and adult abuse had higher incidences of lifetime drug and alcohol dependence than nonabused women (p. 19).

8. Mental health problems (cognitive difficulties, somatization, anxiety disorders, phobias, sleep disorders, fearfulness of spouse, obsessive compulsiveness, etc.) were also noted in victims of domestic violence, in addition to PTSD, depression and substance abuse (p. 19).

The study then noted the observed limitations of the analyzed research studies identified by the SRS meta-analysis. The samples of victims of domestic violence are almost exclusively made up of victims seeking assistance and/or living in shelter, which is "probably not representative of battered women" (Hughes and Jones, 2000, p. 14). The samples are also "small, nonrandom, and drawn from a single site" (p. 14). The limited number of studies that used a comparison group typically assessed differences between battered and non-battered women without controlling for other factors. Of the 42 studies analyzed, only one study (Riggs et al., 1992) compared domestic violence victims to victims of other types of violent crime (marital rape versus stranger rape and marital assault versus other assault). A majority of the studies sample were white low-income or middle-class women; are retrospective, rather than longitudinal, have imprecise and different definitions of violence and psychological distress; and are predominantly clinical and descriptive in nature (Hughes & Jones, 2000, p. 14) Given the relatively recent recognition of PTSD as a formal disorder, as first officially defined in the *DSM- III* (American Psychiatric Association, 1980), field-tested studies and/or longitudinal studies of treatment "efficacy and effectiveness" of PTSD in domestic violence victims are lacking (Hughes & Jones, 2000, p. 13). Over the past two decades, the academic literature on domestic violence and the correlation to PTSD has begun to explore treatment of

PTSD in battered women and preliminary suggestions for treatment can be implied, but there is a need for field testing (p. 14). Hughes and Jones stated that the SRS findings concluded that mental health professionals' diagnosis and treatment strategies are incongruous (p. 10). First, they noted that Crowell (1996) concluded that "the most common diagnosis by mental health professionals for battered women is Posttraumatic Stress Disorder (PTSD)" (Hughes & Jones, 2000, p. 10). Hughes and Jones then contended that:

> the typical treatment strategies for battered women are not those developed for PTSD. Battered women are likely to be just treated for depression or some other psychological disorder. The mismatch of treatment with disorder might not only be ineffective, but may make matters worse. (p. 10)

As stated in the introduction, this observation and conclusion suggests that mental health professionals may lack knowledge and training as to how to properly assess, diagnose, and/or treat PTSD in domestic violence victims, which is the genesis for this research study.

Hughes' and Jones' (2000) report proves to be a useful and insightful framework for reviewing the newer literature. When reviewing the post-1999 studies on domestic violence and PTSD, special attention will be given to any results that support or contradict Hughes' and Jones' generalizations/findings and study limitations. The articles reviewed herein will also be analyzed to determine whether concerns about mental health assessment, diagnosis, and treatment strategies are identified.

Theoretical Framework

Although originally hypothesized for offenders/deviants, the labeling theory provides a theoretical framework for this research study. Developed from a sociological perspective, the labeling theory states that

> "in the course of social interaction, a person anticipates the reactions of others and how these others will view himself. In so doing a person develops his or her own identity and takes on the roles that are compatible with this identity" (Liska & Messner, 1999, p. 117).

A licensed mental health professional who does not recognize the impact of victimization of domestic violence on a client is effectively causing the clinician to "revictimize" the client by diagnosing him or her with an inaccurate diagnosis that will evolve into ineffective treatment along with a lifetime label which will be perpetuated in the client's mind as well as in the insurance databases available to all clinical and medical professionals, insurance companies, and providers. People tend to view themselves as others see them and

then act on those self perceptions and definitions. If a person is socially labeled as a deviant [victims/mentally ill], they come to see themselves as deviant [victim/person who is mentally ill] and behave accordingly." (Liska and Messner, 1999, p.118) Victims who are "labeled" by the court, family or friends begin to view themselves as victims often helpless and hopeless and these feelings perpetuate the "need" to be with or stay with an abusive partner.

Paquin and Jackson (1977) reported that:

> "the fact that the presence of labels had the effect of reducing sensitivity across all targets suggests that labels may create a judgmental set to focus upon the label itself, rather than upon the network of traits and behaviors implied by a particular description of a personality" (1977, p. 114)

Psychiatric labels and suggestive language could inadvertently lead licensed mental health professionals to "believe that they have captured the essence of the client and truly understand complicated clinical phenomena, as well the worldwide view of the client" when in fact they have not and/or do not. (Boisvert & Faust, 2002, p.248) An alternative to the labeling theory would be the strengths perspective, which suggests that clients/victims are best served not by assessing and diagnosing but by assessing and building on the clients' resources and abilities (Bell, 2003). In other words, the strength perspective suggests that the healing process is more effective when the client is empowered than when he or she is labeled. After being emotional and psychologically battered by an abusive partner, the strengths perspective offers a "survivor" not only empowerment, respect, and increased self-worth, it offers her faith and hope in herself and in her future. The strengths perspective is more of a service philosophy than a system of care (Askey, 2004).

Research Design

The research study will be a primarily a quantitative, descriptive survey design with a qualitative component of open ended research questions included in the survey instrument. Descriptive studies are conducted without any independent or dependent variables. Descriptive studies "often represent the first scientific toe in the water in new areas of inquiry" (Grimes & Schultz, 2002, p. 145). Unlike most forms of research, descriptive studies do not have a hypothesis; however, they often help to develop a hypothesis about cause (Grimes & Schultz, 2002). In order to insure that mental health practitioners are not revictimizing or causing harm to imperative that the research empirically examines whether

or not licensed mental health practitioners are making the clinical link between domestic violence and PTSD.

This researcher obtained a list of all licensed mental health professionals in Florida, along with their mailing addresses from Florida's Department of Professional Regulations (DPR) website. The DPR is a subsidiary of the Florida Department of Health, which licenses and monitors all licensed clinical professionals in the state of Florida. This list included clinical practitioners working both in private practice and county mental health agencies in Florida.

From the mailing list obtained from the Department of Health, a letter was sent to each of the listed licensed mental health practitioners requesting participation in the study.

The letter of request gave prospective participants needed study information and the website survey link, with a confidential password to gain access to the study for purposes of confidentiality in the study as well as to maintain participant anonymity. The study was conducted on the Survey Monkey.com website at http://www.surveymonkey.com. Survey monkey is a secure and confidential research website. The cost for using this website to conduct the survey will be $19.95 per month for up to 1,000 responses per month.

The survey website included an informed consent form to be read and signed online by study participants prior to their participation in the study. Participants were required to sign their names on the informed consent forms, but were not be required to provide it on the survey itself. Once collected, informed consent forms and surveys were kept separately to insure the anonymity of the participant both during and after the completion of the study.

Instrumentation

A researcher-designed survey instrument that is a combination of Likert-type scale and short answer questions will be used to survey the sample. Part I of the survey instrument collects demographic and background information. Part II and III of the survey instrument are designed to examine the percentage of Lee County, Florida, licensed mental health professionals who have a working clinical knowledge of the dynamics of domestic violence, and, the percentage who have working clinical knowledge of the impact of trauma on victims of domestic violence. Part II consists of eleven questions regarding client assessment, with a Likert-type scale comprised of six answer choices ranging from 1 = always, 2 = frequently, 3 = sometimes, 4 = rarely, 5 = never and 6 = not applicable. Part III consists of seven questions

regarding client diagnosis with a Likert-type scale comprised of seven answer choices ranging from 1 = less than 10% percent, 2 = less than 30%, 3 = less than 50%, 4 = greater than 50%, 5 = greater than 70%, 6 = greater than 90%, and 7 = not applicable.

Panel of Experts Questionnaire

Prior to the actual research study, this researcher will provide a panel of 5 licensed mental health professionals in Lee County, Florida, a copy of a "Panel of Experts" form containing all questions proposed for use in the study. Each of the experts will be selected by this researcher and approved by a study mentor prior to releasing the questions. The experts were e-mailed the survey questionnaire along with a feedback form, reviewed the survey questions and then provided feedback to this researcher. The panel suggested changing the order of some of the questions and categorizing them differently than they had originally been presented. Adjustments were made to the questions as suggested by the panel. Panel participants will be excluded from participating in the actual study.

In response to the 235 request for participation letters, 32.3% (N=76) responded in some manner. 6% responded via e-mail (N=11), letter (N=1) and telephone (N=2) and reported that although they kept their license active, they were no longer practicing in the field, or were working exclusively with sexual offenders, or were working in a public school setting and did not feel that they would be an appropriate participant for the study. 26.4% (N=64) actually completed the on-line survey, although not all participants answered every question, the possible significance of which will be addressed later.

Analysis

The first 6 questions were demographic questions and the participants were asked to check the answer that best pertained to them. As to demographic question 1, of the 98.4% (N=61) valid total responses, 52.5% (N=32) were Licensed Clinical Social Workers, 42.6% (N=26) were Licensed Mental Health Counselors, and 4.0 % (N=3) were Licensed Marriage and Family Therapists.

In response to assessment questions, of the 61.3% (N=38) valid total responses as to whether the participant addresses domestic violence in couples counseling relationships, 21.1% answered Always (N=8), 36.8% indicated Frequently (N=14), 21.1% stated Sometimes (N=8), 15.8% marked Rarely (N=6), 5.3% said Never (N=2), and no one marked Not Applicable. In response to assessment question 11, of the 79.9% (N=49) valid total responses

as to whether the participant discusses the impact of domestic violence victimization on trauma, 26.5% indicated Always (N=13), 24.5% answered Frequently (N=12), 38.8% replied Sometimes (N=19), 8.2% stated Rarely (N=4), 2.0% marked Never (N=1), and no one stated Not Applicable.

A non-parametric Chi-Square test was run to compare data between the group of participants who were determined to have working clinical knowledge of domestic violence and the group that did not. The test hypothesis is that 50% of licensed mental health counselors will have working clinical knowledge of domestic violence and 50% will not. A statistically significant deviation from the hypothesized values was found ($\chi^2(1) = 43.66$, $p < .05$). Table 1 displays the results of the non-parametric Chi-Square test conducted for Research Question 1 between the group of participants determined to have a working clinical knowledge of Domestic Violence and those who did not have a working clinical knowledge.

Table 1
Participants With Working Clinical Knowledge of Domestic Violence

	Observed N	Expected N
Yes	3	27.5
No	52	27.5
Total	55	
D*f* = 1	Chi-square value = 43.655	Significance = .000

A one-way ANOVA test was run comparing the data of participants who were licensed mental health counselors, licensed clinical social workers and licensed marriage and family therapists. No significant difference was found among the three groups ($F(2,51) = .21$, $p > .05$). The results of the one-way analyses of variance test conducted for Research Question 1 concerning the participants' working clinical knowledge of Domestic Violence compared between two groups based on type of licensure are contained in Table 2.

Table 2. *One-Way Analyses of Variance As to Working Clinical Knowledge of Domestic Violence Between License Groups*

	N	Mean	Std. Deviation
Mental Health Counselors	24	1.96	.20
Clinical Social Workers	27	1.92	.27
Family and Marriage Therapists	3	2.00	.00
Total	54	1.94	.23
D*f* = 2, 51	F = .210	Significance = .811	

Then a one-way ANOVA test was run comparing the data of participants broken into 5 groups based on the number of years licensed. No statistical significant difference was found among the five groups ($F(4,49) = 1.06$, $p > .05$). Table 3 shows the results of the one-way analyses of variance test conducted for Research Question 1 concerning participants' working clinical knowledge of Domestic Violence compared between five groups based on length of time licensed.

Table 3. *One-Way Analyses of Variance As to Working Clinical Knowledge of Domestic Violence Between Groups Based on Length of Time Licensed*

	N	Mean	Std. Deviation
Less than 5 years	16	1.88	.34
6 to 10 years	17	2.00	.00
11 to 15 years	7	2.00	.00
16 to 20 years	7	2.00	.00
Greater than 20 years	7	1.86	.38
Total	54	1.94	.23
D*f* = 4,49	F = 1.063	Significance = .385	

Summary of the Results

The purpose of this proposed research study was to examine whether licensed mental health professionals in Lee County, Florida, are identifying the symptoms of PTSD when assessing, diagnosing, and treating victims of domestic violence. The research questions

presented in this study examined how licensed mental health professionals working clinical knowledge of domestic violence and the impact of victimization of domestic violence on their clients. The research questions also examined how licensed mental health professionals are assessing, diagnosing, and treating victims of domestic violence and trauma. This study found that only 28.3% (N=15) of the 62 licensed mental health professionals in Florida, who participated in this study, are consistently or properly assessing their clients for domestic violence. Astoundingly, this study also found that only 4.8% (N=3) of the total number of study participants demonstrated having a working clinical knowledge of the dynamics of domestic violence.

This study clearly showed that significantly less than 50% of all licensed mental health professionals in Florida, who participated in this study 28.3% (N=15) are consistently or properly assessing their clients for domestic violence. Perhaps part of the reason that licensed mental health professionals are not consistently or properly assessing their clients for domestic violence is due a, at least in part, to the fact that only 4.8% (N=3) demonstrated a working clinical knowledge of domestic violence. The research in this study showed that only 28.3% (N=15), of the 53 licensed mental health professionals in Florida, who participated in the assessment portion of this study, were consistently assessing their clients for domestic violence and only 4.8% (N=3) of the total number of study participants were properly assessing their clients for domestic violence. Even more astounding is the fact that this study shows that of the licensed mental health professionals in Florida surveyed in this study, only 4.8% (N=3) demonstrated a working clinical knowledge of the dynamics of domestic violence.

Implications for Licensed Mental Health Professionals

Prior to this research study, scholarly literature had not yet addressed the issue of how licensed mental health professionals' assessment, diagnosis and/or treatment of victims of domestic violence as well as whether or not mental health professionals are making the critical link between domestic violence and PTSD when clinically appropriate. Rogers and Norman (2005) noted they were able to locate only one study conducted by Schlee, et al. (1998) that particularly addressed the impact of a PTSD diagnosis on the treatment outcomes of victims of domestic violence.

This researcher hopes that this research study will open the eyes of licensed mental health professionals and those that govern and educate them, but also to other researchers

about the need for further research in other clinical and demographic areas as to the assessing, diagnosing, and treating of victims of domestic violence by licensed mental health professionals. In addition, following an exhaustive review of the literature, both pre and post completion of this research study, not one article was located on the impact of labeling specific to victims of domestic violence. Perhaps this could be an area for further research study.

Perhaps licensed mental health professionals are not consistently or properly assessing for domestic violence and only a very few having a working clinical knowledge of the dynamics of domestic violence, due to the fact that prior to the completion of this study, research had not yet explored, examined or addressed these areas, and as a result, were unaware of the fact that these critical clinical issues are in such disarray. Now that there is some scholarly awareness that these clinical issues and conditions are in such disarray, further research can explore, examine, and address this significant clinical gap in both knowledge and client care.

Violence in families can be extremely destructive both physically and emotionally. Counselors must first and foremost keep the safety of all parties involved, including the therapist, as the primary concern. If there is any possibility that harm could be forthcoming while in therapy, the counselor must take appropriate action to prevent such from happening. Given the prevalence of different forms domestic violence, counselors need to be aware of the covert and overt signs of such practices. Without appropriate observation skills, counselors can overlook and inadvertently subject individuals to further pain and suffering. Furthermore, the therapist must be conscious of the impact that any given therapeutic approach may have on changing interaction patterns.

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