*Volume 4 (17), Issue 1–2 (28–29), 2015*
*pp. 01-21*

DIALOGUE IN PRAXIS
A Social Work International Journal
@IUC.Dubrovnik

# Understanding the connections between intimate partner domestic violence and mental health within the European context: implications for innovative practice

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*The article highlights the traumatic impact of Intimate Partner Domestic Violence (IPDV) on women, the complexity of their responses and the connections between IPDV and mental ill health in the European context. Prevalence statistics indicate the scale of both IPDV and of mental ill health among IPDV women victims, as well as highlighting the impact of societal attitudes on disclosure. The paper highlights gaps in existing service responses which seek to break down the barriers preventing women from using services are identified. The potential of applying the new models of recovery being modelled in mental health to women experiencing IPDV is explored.*

*Keywords: Intimate Partner Domestic Violence (IPDV), Mental Ill Health, Victim Blaming, Mental Health Providers, Empowerment and Recovery.*

*Introduction: The Key Experience and Issues*

Intimate Partner Domestic Violence (IPDV) is likely to be experienced as a trauma for the victim. This is due to the high level of personal commitment an intimate relationship entails, its impact on one's personal and social identity, the violation of the high level of trust invested in the relationship, and the sha-

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red bond that might have developed (Cavanagh, 2003), especially if there are children.

The majority of IPDV victims in Europe are women (Wave, 2011); this paper focuses only on this group.

The often ensuing difficulties resulting from this trauma make for a daunting list. These include; physical injury; psychological stress which may develop to an identified mental illness; need to leave one's home; relocate oneself and one's children in an unknown environment; reduced standard of living and disposable income, loss of social status; loss of social support network; loss in self-confidence; difficulties in the relationship with one's children due to the stress they and the woman (mother) are experiencing, difficulties in relationships with one's in-laws and members of one's own family (Radford & Hester, 2006).

The shame and guilt associated with this experience need to be understood in the context of the background of the person who is the victim of violence. However, while victims of violence, across different societies can be the object of sympathy, pity and social support, this is less so in the case in IPDV.

Research indicates (reference the evidence for these assertions) that women report that they know intuitively that an IPDV incident should not be disclosed to anyone; children report that they too know that observed incidents of IPDV should not be disclosed to their friends, teachers, or extended family members. Why is this the case?

We are all socialised to believe in the positive value of intimate relationships, and in the need to protect such relationships from external pressure. Women are often persuaded, and at times literally forced, to return to their abusive partner by their own families, as the stigma associated with being either a perpetrator, or a victim, of DV is perceived to be a stain on the reputation of the whole family.

Both men and women invest in their intimate relationships, and are socially judged as to whether they have managed these relationships well or not. However, as Hochschield (1983) indicates, it is assumed that it is up to women to ensure that these relationships work, rather than it being seen as the responsibility of. This stance relates to the gendered assumptions that women are better in expressing emotions and in nurturing relationships, embedded in our universal concept of motherhood. Furthermore, in the majority of cases it is the woman (or mother) – attacked by her male partner or the father of her children – who is perceived as having the sole responsibility for the care of the children in IPDV situations (Hester, 2011).

Hester's (2011) concept of women as 'culpable victims' encapsulates well the prevailing social attitudes in Europe - where victims of IPDV are blamed for their own victimisation. In her analysis of data from two Scottish studies, Cavanagh (2003) has highlighted the complexity of the woman-victim's experience. This is mediated by the mixture of the wish to restore the relationships, the impact of the interactive relations with the perpetrator, fear, and humi-

liation. Women's responses are therefore often both ambivalent and complex in nature. They can include avoiding the situation rather than tackling it head on, trying to pacify the aggressor, moving to more confronting strategies of persuading the perpetrator to confront his violence, leaving, returning, and leaving again.

Victims who feel unable to unburden themselves and ask for support are not only more trapped than those who are able to break the silence, but are also more likely to stay in the abusive situation demonstrating to the perpetrator that he can get away with the violence. This can also send a message to children, who witness IPDV, that there is no way out of the helplessness, anger and sadness they feel.

Research also indicates that both the women and child victims of IPDV have a high prevalence of mental ill health symptoms and difficulties, as well as behavioural disruption and suicide attempts (Humphreys & Thiara 2003; Lapierre.2010; Rose 2011), indicating that the helplessness experienced is expressed in ways which harm oneself and also others. These situations sap the woman's energy (Dobash & Dobash, 1992), and often come after a long period in which her authority as a mother has been undermined by the perpetrator (Lapierre, 2010). Hence reducing the victim's ability to function as a mother. This in turn harms both the child and the woman, even if unintentionally so. If anything, women in this situation have an increased sense of responsibility towards their children, related to their recognition that the child is suffering as a result of IPDV and their internalised sense of guilt. The evidence as to their mothering abilities ranges from becoming abusive towards their children to trying hard to compensate the child, with most of them being just as good a mother any woman who has not been a victim of IPDV (Lapierre, 20110). Children reflect the impact of observing violence, without being a victim of it, in a variety of ways, such as disrupted behaviour at home and at school, difficulties to concentrate on school work, and/or lagging behind other children in achieving developmental milestones (Humphreys & Stanley, 2006).

*Learning from European Background Data*

An analysis by the Council of Europe (2002) of ten domestic violence (DV) prevalence studies found that 1 in 4 women experience IPDV during their lifetime, and 6–10% of women are the victims of domestic violence in a given year. Wave (2011) quotes a figure of 2 million women victim of IPDV per day, and 100 million over their lifetime (p. 4).

*Table 1:* European Identification of Domestic Violence – QC11: Do you know of any woman who has been a victim of any form of domestic violence?

| | In your circle of friends and family | In your immediate area or neighbourhood | Where you work or study |
|---|---|---|---|

| | yes | no | dk | yes | no | dk | yes | no | dk |
|---|---|---|---|---|---|---|---|---|---|
| EU27 | 25% | 74% | 1% | 21% | 77% | 2% | 11% | 86% | 3% |
| male | 21% | 79% | 1% | 18% | 80% | 2% | 9% | 88% | 3% |
| female | 29% | 69% | 2% | 23% | 75% | 2% | 13% | 83% | 4% |

*Source:* Question QC11, European Commission (2010) Special Eurobarometer 344, p. 30

Table 1 highlights that more women than men know of such victims, and its assumed rarity among those we are familiar with. The figures also indicate that most participants in the study were ready to respond to the questions, and only very few chose the 'don't know' option.

However, most researchers (Humphreys & Thiara, 2003) agree that the published figures represent an underestimate of the real prevalence, due to the shame attached to an admission of being a victim of IPDV, coupled with the fear of reprisal. The hidden nature of this experience and the predominant reliance on victim self-reporting, challenge the ability to undertake accurate mapping of its prevalence. For example, UK women experience an average of 35 incidents before contacting the police (Starmer, 2011), all of which do not appear in the existing statistics. Similar findings come from Poland and Greece. For example, 97% of Poles surveyed have heard of DV, and 80% consider it unacceptable (Niebieska Linia, 2011). There is a telephone helpline, the Blue Line, which receives as many as 11,000 calls per year since its inception. The police have also issued a Blue Card which provides victims of DV with information, and the number of police interventions related to DV has gone up from 72,000 in 1999 to 96,773 in 2005. Yet only 26% of victims have asked for help, and of those only 14% have had a response from the police, (TNS OBOP, 2007). In Greece the General Secretariat for Gender Inequality (2005) reports that of 80% of women reporting IPDV, 65% continue to live with the perpetrator.

Ethnic minorities and migrant women are more likely to delay, even further, disclosure than other women, due to strong community codes of not disclosing negative experiences to the majority, mistrusting the police due to the latter's attitudes towards ethnic minority and towards women reporting IPDV, and/or fears of being deported if the police are approached (Palmer & Ramsay, 2002).

Recent prevalence data from Greece, Italy, Poland, Slovenia and the UK illustrate not only the difficulty of obtaining data, but also of the variations between countries and type of violence. Thus in Poland, 39% of adult women report experiencing DV (Public Opinion Research Centre, 2010), compared with 25% in the UK (Home Office, 2010), 14.3% in Italy (Istat, 2007) and 20% in Slovenia (Zaviršek, 2004; Leskošek, Urek & Zaviršek, 2010). The one and only survey of IPDV in Greece was carried out in 2002–3. Of the 1200 women sample 65% reported psychological abuse, 3.6 physical abuse, and 3.5 sexual abuse. When reporting on abuse by a previous husband, 39.7% declared that they have experienced IPDV (Wave, 2011, p. 100). This discrepancy in the

figures is perceived to be the outcome of Greek women not treating psychological abuse as IPDV. Furthermore, a recent Greek study aimed at identifying emotional and physical abuse in postpartum found that 35.6% of new mothers screened reported intimate partner violence (Vivilaki *et al.*, 2010).

Thus researchers and policy makers in this area are faced with the issue of the reliability of the figures.

Pertaining to type of IPDV, emotional abuse tops the list across Europe, followed by physical violence. In comparison to physical violence, emotional abuse is often less visible and difficult to define, which perhaps explains why spending on responding to physical violence outstrips, by a huge margin, the response to mental health difficulties in the aftermath of DV. For example, the annual financial cost of domestic violence to the UK's National Health Service (NHS) has been estimated at £1.2 billion in relation to the cost of treating physical injury, while the cost to mental health services is estimated at £176 million (Walby & Allen, 2004). It would seem that an inverse relationship prevails between the recognition that emotional abuse is outstripping physical abuse, vs. the investment in tackling it.

Domestic violence can occur at any social strata, including health and social care professionals (Ben Ari & Dayan, 2008), and any ethnic group. While the rate among different ethnic groups in a given society does not seem to vary the rate of disclosure of domestic violence incidents by ethnicity varies considerably. In some ethnic groups the shame of such a disclosure is felt more keenly than in others, and may lead to reprisals from the woman's community in addition to potential reprisal from the perpetrator (Refugee Resource Project and Asylum Aid, 2002, Palmer and Ramsay, 2002). Consequently women from such a group are more reluctant to disclose than women from the majority socio-cultural group, as highlighted above.

Reluctance to disclose per se is a feature in any society, reflecting the sense of shame & guilt felt by the woman, and the complexity of the response, already outlined above.

### *The Impact of Intimate Partner Domestic Violence on Women's Mental Health*

While there are shining examples of women surviving these experiences (Surviving-Domestic-Violence.com, On line) this is not the case for many others.

Although the physical scars are likely to heal in many cases, the emotional and social ones could either take longer to heal, or will not heal. The known effect of only observing IPDV violence by children is long term and can impede their intellectual, psychological and social development (Humphreys & Stanley, 2006). It also impacts on their mothers who often indicate their sense of guilt of being unable to protect their children from observing violence, and think of themselves as failing to be good enough mothers as a result (Humphreys, Thiara & Skamballis, 2010). However, the long term impact on

the psychosocial wellbeing of women has not been researched extensively. The evidence pertaining to the impact of IPDV on women's mental ill health from a meta-analysis of 18 studies highlights that to 64 percent of women experiencing post-traumatic stress disorder, 48 percent suffering depression and 18 percent attempting or committing suicide (Itzin, 2006).

High levels of depression, anxiety, eating disorders, suicidal thoughts and at times suicide attempts, poor self-esteem and difficulties to concentrate have been identified, while the more frequent clinical diagnoses attributed to this population are depression and personality disorder (Itzin, 2006).

Compared to the general population, women experiencing mental ill health are more likely to be victims of violence (Coid, Petrukevitch & Chung, 2003). Contrary to the myth that people experiencing mental ill health are often engaged in harming others, it is the rate of self-harm which is much more frequent than media coverage would suggest (Taylor & Gunn, 1999; Pilgrim & Rogers, 2006). This would imply that women experiencing mental ill health are more likely to become victims of IPDV, but does not negate the opposite inference, namely that this experience may lead to mental ill health in its own right.

Viewing IPDV as a *symptom* of a woman's mental health state rather than as an underlying *cause* can contribute towards absolving the abuser of responsibility for the effects of his actions, and has implications for the services offered to the woman. Labelling a woman as having mental health problems has been shown to have ramifications for her contact with her children, as she may be unable temporarily to look after them. In addition once the children are removed it is difficult for the mother to get them back (Humphreys & Thiara, 2003). Child protection workers might begin from the assumption that experiencing mental ill health almost automatically disqualifies women from being good enough mothers. The removal of the children usually has a knock on negative effect in terms of reducing further the woman's self-confidence in her key role of being a mother, and of labelling her as incapable to look after her children for a long time to come.

Furthermore, the complex needs of women experiencing IPDV and mental health problems can make for circuitous referral pathways. When the underlying causes of their difficulties go unrecognised, a mismatch between their needs and the services on offer often ensues. Humphreys and Thiara's (2003) research revealed that survivors of IPDV came into contact with up to ten agencies before their needs were identified and appropriately addressed. Eight years later, Rose *et al.* (2011) highlighted the high prevalence of women who use mental health services that have experienced domestic violence. Based on their qualitative study of women users of mental health services in a deprived area of South London, this group of researchers (which included services users), concluded that the medical model of mental ill health itself is a key barrier to understanding these women and to enhancing the disclosure of domestic violence by them, because of its focus on symptoms rather than on the underlying problems the symptoms reflect.

At this stage of our knowledge, of mental ill health and of domestic violence, we can only conclude that while feedback relationships between these two phenomena can be assumed, having a mental illness per se is unlikely to cause domestic violence. However, the higher likelihood of such an experience in successive generations of the same family, and that of child abuse (often found in life histories of people with Personality Disorder in particular; as highlighted by Castillo (2003) may indicate a psychosocial vulnerability of the victim matched by the perpetrator's life experiences and qualities that lead to the manifestation of such violence (Buchbinder & Birnbaum, 2010).

The many testimonies and the fewer systematic studies in existence shed light on the subjective experience of IPDV and mental ill health, indicating how far reaching is its negative impact , as already stated above. (Cavanagh, 2003; Lapierre, 2010).

Of particular interest in this context is research that investigated how women working as mental health professionals have experienced domestic violence and how they dealt with the impact of such an experience. Ben Ari and Dayan (2008) have conducted in-depth interviews with nine such women in Israel, who self-selected themselves for this purpose. All of them have felt that IPDV had a profoundly negative effect on their self-image and their key relationships. Furthermore, it affected their ability to work with other women with similar experience at least temporarily, in that during the acute stage of IPDV and for a time to come they were reluctant to bracket themselves as 'battered women' and were unsure of their ability to listen and take in the similar experience women clients had. However, only one of the nine interviewees has decided to discontinue her work in the mental health field. The others describe a long period of splitting their identities at home from those they upheld at work, and the difficulty in accepting for themselves the identity of the 'battered woman'. Yet they felt a tremendous relief once they were ready to accept that identification and to disclose the experience to colleagues, family members and friends. The interviewees describe the considerable support received following the disclosure, and how this has helped them in re-integrating their professional and new personal identity together. Some of them have gone for counselling, which they also cite as a source of help in moving from the splitting to the re-integration phase.

*Explanations of IPDV and Related Mental Ill Health*

Explanations for IPDV are wide ranging and variously located on a continuum of viewpoints. One of the dominant perspectives concerns blaming the victim whereby a woman's behaviour is viewed as an antecedent of domestic violence. Pathologising women in this way contributes to absolving the abuser of culpability. In a similar vein, moralist perspectives pinpoint family breakdown and divorce/separation as mitigating circumstances in cases of domestic abuse. Further explanations for IPDV include the discourse of sanctioning privatised

violence; experiencing violence during childhood; the valorisation of male aggression; male power and male powerlessness; and a crisis of masculinity. Alcohol consumption, religious affiliation and sport are also cited as triggers of domestic violence. Greek research (General Secretariat for Gender Equality, 2005) highlights that before the abuse most perpetrators (42%) are under the influence of drugs (15%), psychotic drugs (10%) and alcohol (30%). Yet a Slovenian survey has found no evidence for consumption of alcohol leading to increased domestic violence incidences (Leskošek, Urek & Zaviršek, 2010). In Scotland, football matches between Glasgow's two rival Catholic and Protestant teams consistently lead to significant increase in domestic violence incidents, as though the aggression on the pitch, enhanced by beer drinking, is replayed at home (Jack, 2011). Caution should be exercised when examining the origins of IPDV; some of the explanations discussed here focus on *contributory* rather than *causal* factors of domestic violence.

Poverty is likewise viewed as a social marker concerning the distribution of risk though it is not perceived as having a causal effect on domestic violence (Durfee & Messing, 2012). While wider structural inequalities need to be taken into account when analysing the emergence of IPDV, this is not to suggest ignoring personal responsibility, or psychological factors at play. Conversely, risk factors – such as poverty and childhood experiences of violence – can have a bearing on people's inclination to apply domestic violence as a solution to their intimate relationship problems, or to how they respond to IPDV (Buchbinder & Birnbaum, 2010; Durfee & Messing, 2012). Yet it is important to guard against overly deterministic explanations of IPDV, given that just as biology is not destiny, nor is nurture. Individuals who have all the known prevalence characteristics ticked off against them do not homogeneously follow the trajectory to domestic violence.

Although IPDV transcends social class, education, religion, 'race' and cultural background differences, its historical, cross-national common denominator appears to lie in the power differential between men and women. In a recent convention on preventing and combating violence against women and domestic violence the Council of Europe (2011) recognises the deep roots of gender inequality:

> *'...violence against women is a manifestation of historically unequal power relations between women and men, which have led to domination over, and discrimination against, women by men and to the prevention of the full advancement of women...' (Council of Europe, 2011, p.2).*

Efforts by the Council of Europe to eliminate violence against women and domestic violence highlight the need to develop substantive gender equality 'including by empowering women' (Council of Europe, 2011, p.3).

The deep-rooted nature of gender inequality is of central importance to feminist explanations of domestic violence which view power within patriar-

chal societies as concentrated in male hands. Women's historical and global limited access to power within the public spheres of education, employment, politics, judiciary, religion and health and corresponding lack of power within the private sphere of the family are seen as mutually reinforcing each other. Thus the gendered power dynamics of domestic violence interact with those of wider society. The longstanding feminist articulation of 'the personal is political' (Millett, 1970) has continuing resonance with international domestic violence patterns today.

Minority ethnic groups may differ from the majority in terms of gender inequality and consequently in reactions to domestic violence. Examples include Roma women across Europe (Refugee Women Resource Project and Asylum Aid, 2002, country reports on Albania and Bosnia Herzegovina), the quest for specialist refuge for black ethnic minority women (Gill & Banga, 2008), and the rare but shocking cases of honour killing among Muslim families in the UK (Ashencaen–Crabtree, Husain & Spalek, 2008).

It would seem that the explanations are rooted primarily in attitudes towards use of violence in intimate relationships, rather than in structural or generic psychological factors, though these too play a part.

*Barriers to Adequate Support*

*a. Difficulties experienced in disclosure and help seeking*

The rate of awareness of DV in EU countries is high, as Table 1 has indicated; 98% of the general population have heard about DV and consider it unacceptable behaviour according to the Eurobarometer of 2010. However, the gap between this awareness, requesting help, and being responded adequately continues to be high too.

As outlined above in the section on background data, in England, Greece and Poland the majority of the women reporting experiencing IPDV either opt not to ask for help, or do so only after many incidents. These findings illustrate how difficult women experiencing IPDV find it across Europe to disclose and to seek help for IPDV.

As already mentioned, most European countries do not have legislation enabling the removal of the perpetrator in the case of IPDV without a lengthy legal process. Exceptions where such a removal is enabled include Germany and Austria.

Rose *et al.* (2011) looked at the barriers preventing women who use mental health services from disclosing that they had experienced domestic violence. These include the fear that the disclosure would not be believed, that it could lead to further violence, fear of repercussions related to immigration status in the case of migrant women, and that it entails shame and blame, inclusive of self-blame. Women were more ready to disclose to professionals they felt they had good relationships with. Cavanagh's study (2003) mentioned above has portrayed the complexity of women's responses to IPDV and the reasons behind it.

*b. Approaches to IPDV by mental health service providers*

The contrast between awareness of being violated and taking the necessary action by women victims is echoed to an extent by the professional response in the field of mental health to working with them.

*Attitudes of Mental Health Professionals*

In any mental health intervention, the approach by the professional provider is of key importance, because of the sensitivity of the issues at stake and due to the low self-confidence of the service user at the referral stage. In the context of IPDV this is also justified by the likely and understandable fragility of the woman's state of mind at the post traumatic phase. A non-judgemental, yet emphatic, attitude on the part of professionals, grounded understanding of what women stand to lose by leaving an abusive relationships, coupled with good assessment and trust building skills is indispensable for a woman at a low ebb of self-esteem, in fear of her life, ashamed and feeling guilty of finding herself in this position. However, unless coupled with an approach that gives women tacit permission to discuss the IPDV on her own terms, the above will not suffice.

The rather meagre existing evidence of this aspect illustrates the discomfort mental health professionals experience when it comes to working with this client group. As part of the Emilia project (an EU framework 6 project on mental health and social inclusion, see Ramon *et al.*, 2010; Ryan, Ramon & Greacen, 2012), a survey was carried out among the staff of the eight demonstration sites involved in the project about the areas they identify as of high relevance for their practice yet about which they would want to increase their knowledge. Domestic violence topped the agenda. In response, a small scale pilot project of training on this topic took place, including the professionals in the Greek site (Athens, Epapsy) and the Polish site (Warsaw, Institute of Neurology and Psychiatry). The interactive training programme[1] included several case studies designed to increase awareness of the complexity of the issues this work entails, and of the range of issues and emotions this presents the staff with, in addition to information about prevalence, explanations, and intervention methods. The training programme was evaluated before and after its delivery. This exercise has highlighted that staff members had many reservations as to their ability to appropriately support these women, and tended to refer them to other services as a way out of this dilemma. However, this strategy did not help, as the women were re-referred to mental health services because their difficulties in this area did not disappear; and furthermore the message transmitted to them in this referral and re-referral process has been that IPDV is not an issue the mental health provider welcomes.

In the study by Rose *et al.* (2011) mentioned above, professionals felt impeded by a lack of clarity about role boundaries, their competence and confidence

in working with this client group. To this list they have added the need to navigate between competing demands on their time, the presence of the abusive partner in the conversation, and doubts about their competence to do so.

A stumbling block that has not been researched is the observation that many professionals seem to indicate that they do not understand why women who have been abused in this way do not leave the perpetrator. This lack of understanding is tinged with blaming the woman for further abuse, by not taking the necessary safety measures. Yet the reasons given above for the difficulty in responding to IPDV highlight the very real difficulties these women face in making the decision to stay or not to stay with the intimate partner. Furthermore, the lingering hope that the perpetrator wants to, and can be reformed, the wish not to lose one's home and social position lurk in the background together with the possibility of blaming oneself for bringing about the violence. While the decision to leave the perpetrator must remain that of the woman herself (unless she is severely mentally ill or mentally incapacitated), it stands to reason to assume that if mental health professionals who work with her have managed to develop a good trusting relationship, they may have a pivotal role in enabling her to reach that decision sooner and to weigh the pros and cons of each option she may have. Consulting and involving other services while maintaining the contact with the woman may be also a useful tool in such an instance.

Slovenian research (Leskošek, Urek & Zaviršek, 2010) highlights that women with mental health difficulties are not accepted in their local domestic violence refuge services. The reasons given include:

> *'We are not trained to deal with women having mental health difficulties'.*
>
> *'We are afraid how other women will accept women with mental health difficulties'.*
>
> *'We do not know enough about mental illness so we do not know how to react'.*

While these are valid reasons, they beg the question as to why suitable training focused on mental health issues is only rarely provided.

Thus it would appear that this sub-group is likely to be doubly shunned by both mental health service and domestic violence service providers. Furthermore, the providers seem to collude with the dominant lay attitude to this experience in Europe, where the discomfort felt about domestic violence of any type is insufficient to lead to positive action, or to attitudinal change.

Perhaps the need to treat this group of women as 'others'– i.e. the people the providers assume they will never become – may stem out of the fear that IPDV can happen to everyone, including to mental health professionals. Yet the rare example of researching women professionals experiencing IPDV (Ben Ari &

Dayan, 2008), highlights that the response of colleagues to the disclosure of IPDV has been usually very supportive and made a huge positive difference to the ability of the battered woman professional to become a survivor of domestic abuse.

*Existing Range of Services for Women*

Social services, hospital accident and emergency departments, family focused services, mental health services, and educational institutions are likely to be the settings in Europe where the impact of IPDV might be detected, and at times disclosed if trusting relationships are in place. If known, the service providers would respond usually by referring the women to a specialised service. Such a service is more likely to be in the not-for-profit voluntary sector, and may include also advocacy (Coy & Kelly, 2011) and re-housing (Jones, Bretherton & Croucher, 2010). In a number of European countries such services are far and between. As highlighted above, attitudes within mental health services and within the specialised domestic violence agencies towards women with the dual experience of IPDV and mental health issues is unsatisfactory.

Some European countries have made an effort to co-ordinate their DV multi-agency range across the criminal justice, health and social care services. Yet fragmentation and contradictions in practice continue (Hester, 2011). A greater focus on women at high risk prevails, which has its positive and less positive aspects in paying insufficient attention to prevention of IPDV.

At present most European countries have telephone help lines available for women to contact, as a first port of call, as well as police emergency numbers. They can also approach their primary health care service.

While more women use the internet as a source of information and support, many women in Europe do not know of the existence of help lines. The anonymity of telephone help lines is perceived as facilitating disclosure, but it stands to reason that it might be an inhibiting factor for some callers. Likewise disclosing to one's family doctor can be relatively easy if relationships of trust exist. Calling the police is usually a drastic step, because of its connotation with crime and punishment, and its reputation as a bureaucratic, largely unsympathetic, organisation which considers domestic violence to be of less importance than other offences. Across Europe, many women withdraw their initial complaint to the police under pressure from the perpetrator and their extended family; the police are unable to proceed if a complaint is withdrawn.

If disclosing, women may be referred to a support group where they would meet women experiencing similar IPDV situations, will learn from the group facilitators and from the other participants of the options they have as to how to handle their own situation, and of existing services. A minority of women go into counselling and psychotherapy and an even smaller group would bring their partner to the therapy.

Refuge services exist in most European countries, albeit not in the numbers or level of provision required. While a refuge is a lifeline for women in need, it comes with a considerable cost of being uprooted from one's own (and one's children's) environment. In most European countries it is usually the victim who is forced to leave her home, as existing legislation makes it complicated to remove the perpetrator against his will, even when convicted. Perpetrators rarely disclose and rarely seek treatment; when found guilty they are likely to be forced to participate in group work within the local criminal justice system. Jones, Bretherton and Croucher (2010) highlight the issues entailed in enabling this group of women to remain in their homes.

It would seem that only few of the existing services are designed to overcome the barriers listed above. Furthermore, while these services can be seen as having in principle a secondary or tertiary preventive function, none of them tries to tackle primary prevention. In addition, the existing provisions are focused on supporting women to survive the more immediate risks, rather than concentrating on how to ensure they move from being victims to becoming a person who has survived the experience of IPDV. Working with women towards leading a life beyond this experience which includes having dreams, ambitions, use of their potential strengths, as well as contributing towards a good life for others, remains a missing focus in most services.

*Discussion*

Above, we have highlighted the traumatic impact of IPDV on women, the complexity of their responses and the connections between these two factors and social attitudes towards IPDV in Europe. These are elements that have to be taken into account when considering the type of services needed to support victims of IPDV.

Furthermore, the gap between the barriers to accessing and utilising existing services and the services on offer raises the question of what are the reasons for the gap? And how can the gap can be bridged?

The development of an innovative strategy that would attempt to provide a better response, can benefit from considering the relevance of the current 'quiet revolution' taking place in mental health services, focused on the new meaning of recovery, to this client group. The new meaning, constructed initially by US service users, consists of recovery as being the ability to live better with the illness and living beyond it (Davidson, 2003). This implies that while symptoms and negative experiences may not disappear, they become better managed by the person, and the engagement in activities beyond focusing on the illness supports their social inclusion and ability to lead a more fulfilling and socially valued life. The longitudinal research on recovery, most of which was carried out in Europe (Davidson, Harding & Spanoil, 2005), and the many recovery oriented projects established since (Ryan, Ramon & Greacen, 2012) have amply demonstrated that this is possible. This approach is rooted in the

strengths model and the evidence related to its implementation (Rapp & Goscha, 2012). The model promotes the idea that people with a long term illness or a disability have strengths and not only deficits and weaknesses, even if they had negative experiences in their lives. Through activating the strengths people can better confront the difficult issues they may face. The examples of women experiencing IPDV who became survivors who moved out of victimhood illustrates the likely value of this approach to this area of human experience (e.g. the cases of Fiona, Gillian and Sarah on Women's Aid, on line).

We wish to argue here that it would be useful to apply a similar approach in working with women who have experienced IPDV and mental health difficulties. Like other people experiencing mental ill health they too deserve to be supported to improve their ability to be in control of their lives, regain self-confidence, and use their strengths whether as mothers, partners, friends, learners or workers.

This objective is best met within a recovery – oriented health promotion approach, which tackles in parallel the external stigma towards victims of IPDV and the stigma that each victim has internalised about herself (see research on internalised stigma (West *et al.*, 2011).

This dual-pronged orientation should be supported by structural measures, such as improved legislation in securing the rights of this group at the European level and at each member state of the EU, as well as public campaigns to increase awareness and reduce stigma towards victims of IPDV. The current UK wide Time-To-Change project on reducing stigma in the field of mental health provides a good example of the wide range of groups to be reached and the methods to be used for this purpose ( Clement *et al*, 2011, London and Evans-Lacko, 2010) work of Wave highlights the potential of such an approach in the field of DV. Wave (2011) carried out a European survey, highlighted good practice models and policies in the making (e.g. concerning ethnic minorities and DV in England, Hungary and Slovakia – see Thiara, 2002), and a training programme. The good practice models cover all three levels of intervention, such as public awareness, state action, prevention in the health services, and multiagency collaboration, programmes for perpetrators. Tellingly, none of the examples focuses on IPDV and mental health. The Wave evaluation of the different intervention projects shows the wide range of activities already undertaken in this field, many with the active support of the EU, identifying what they can offer but also what they are not good at. It would seem that it is difficult to assess the effectiveness of public awareness projects, while the more focused projects on intervention with either victims/survivors or perpetrators are often limited in their scope and their sample.

The increase in self-confidence and ability to control one's life is best encapsulated in the WRAP (Wellness Recovery Action Plan) programme, developed by Ellen Copeland, a US service user and a qualified psychologist (Copeland, 1997), which is also practised successfully in Australia and the UK (Evans & Sault, 2012). The core of this programme is the activation of existing

personal abilities and external support from family, friends, and service providers in pursuing the specific objectives of wellness and recovery a person may have. Within the context of IPDV it is of particular importance to ensure that personalised plans are not focused only on relationships with children, but also include other areas of women's life, such as training, employment, and having a supportive social network. These strategies do not exclude clinical and medical interventions where relevant, but they prevent the medicalisation of the person and her experience.

The necessary structural, economic, social and psychological interventions are interdependent. For example, enabling and encouraging women to re-enter employment needs to happen at the individual and support group level. However, without adequate child care provision – a structural tool – women who are mothers to children will not be able to work. Likewise, without support in reducing the initial high level of the psychological trauma women will not be able to move on to live on their own, or engage in vocational training.

We are aware that this interdependency makes it all the more difficult to implement a wellbeing promotion policy in practice. Likewise, the transdisciplinary nature of the input necessary in working with this group, given its multiple difficulties, also increases the complexity of enhancing good practice.

We are currently engaged in testing out the usefulness of the line of intervention proposed above within an EU funded exploratory project (Empower Women and Providers: Domestic Violence and Mental Health, www.empowerw.eu ). The project provides women with IPDV and mental health difficulties with an interactive small group training programme focused on enhancing self-confidence and control over their lives. It also enables some of them to be engaged further in a training programme to become co-facilitators for women support groups. In parallel, mental health providers are given the opportunity to participate in a training programme focused on increased awareness, assessment and relationships building skills in this area. A pre and post programme evaluation is in place. The partners to the project are academic institutions and practice agencies based in England, Greece, Italy, Poland and Slovenia. The initial findings have been positive, but it is necessary to wait for the completion of the follow up evaluation to be able to state how successful this approach has been in its implementation.

## *Conclusion*

This article has attempted to make sense of IPDV and mental ill health in the European context, a neglected area in terms of understanding and research. To this end, the significance of experiencing IPDV and its impact for women was outlined, followed by the presentation and examination of prevalence data, the barriers to disclosure and seeking help, the range of interventions available, and the gaps remaining. The text looked at the discomfort mental health providers often experience in working with this group, the likely reasons for it, and

its impact on women service users of both mental health and domestic violence agencies. The interdependency of different types of intervention was highlighted, side by side with the lack of good enough legislation concerning the removal of perpetrators on the one hand and of interventions that focus on enabling women to move beyond coping with the here and now on the other hand.

While the existing interventions have a valid place within a mental health promotion perspective to these issues, it has been proposed that an approach focused on the application of the new meaning of recovery to women experiencing IPDV may provide a positive contribution in enabling them to move from being victims to becoming survivors. This application includes the promotion of wellbeing, regaining control over one's life with increased coping competencies, being encouraged and supported to develop their strengths, to have ambitions and to embark on fulfilling them.

Furthermore, fundamental attitudinal change and up-skilling have been identified as necessary among mental health providers who work with this group of women for them to make a more positive contribution and for this move from victim to survivor to have a real chance of succeeding.

## *Note*

[1] A copy of which can be obtained from Mojca Urek; Email: mojca.urek@fsd.uni-lj.si.

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