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Mental and Physical Health Symptoms of Family Court Intimate Partner Violence Petitioners

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Introduction

The negative impact of intimate partner violence (IPV) on both physical and mental health is emerging as an international issue as it affects women across numerous cultures and demographics.[1] Further exploration as a global concern reveals IPV has a far reaching negative impact on the mental health of women and is a major public health problem for women worldwide.[2] IPV research, including mental health evaluations, has been conducted in several countries. A Pakistani study reported 73% of Pakistani women had prior histories of physical abuse and felt anxious or depressed.[3] A Nicaragua study estimated spousal abuse accounted for 70% of reported mental distress in married women and that abused women were 6 times more likely to be suffering from emotional distress.[4] In the United States, over 10 million Americans experience IPV each year [5–7] with women compared to men experiencing greater physical and psychological consequences of IPV.[8,9] Further underscoring the extent of the problem among women, a national prevalence study conducted by the Violence Against Women Office and the Centers for Disease Control and Prevention reports a lifetime IPV prevalence rate of 22 percent.[9] Moreover, IPV is associated with an annual cost of approximately $8.3 billion for medical care, mental health services, lost time from work due to injury and death[10], a figure that does not consider additional costs associated with prosecution, defense, incarceration, and foster care.

The cost of mental health services is due to the co-morbid mental health burden associated with IPV which is well-documented in clinical samples. Diagnosis include but are not limited to depression[8, 11–15] and post-traumatic stress disorder (PTSD).[13, 15–17] For example, one clinical study estimated depression is 2.76 times more prevalent among IPV victims compared to non-victims, and PTSD is 3.27 times more prevalent.[18] IPV victims are also more likely to attempt suicide than non-abused women. [19–21] Relevance of these data based on clinical samples to court settings, another venue where IPV victims commonly present, is unclear.

Despite research highlighting the co-incidence of IPV and psychiatric conditions, the mental health burdens associated with IPV remain largely unrecognized and poorly treated[22] despite whether this burden is caused or exacerbated by IPV.[18] The apparent strength of the

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associations between mental health burden and IPV are correlated to the time proximity of the abuse and the mental health assessment, especially for those offenses perpetrated within the preceding 12 months.[18] There also is some indication IPV victims with mental health related conditions may be more likely to reunite with their abusive and controlling partners. [22] As many IPV victims seek both shelter and Protection Orders (POs) from courts in response to recent acts of violence, these venues may provide opportunities to both screen and refer IPV victims for coincident mental health issues.

Along with mental health burden, IPV victims also experience elevated physical health problems, both acutely and chronically.[2, 8, 15, 22–26] IPV victims are at a significant risk for increased mortality, injury and disability, problems with general health, chronic pain, substance abuse, reproductive disorders, and poorer pregnancy outcomes.[15, 22–24] A female IPV victim is likely to sustain acute injuries to her head, face, neck, thorax, breasts, or abdomen.[15, 23] These types of injuries can lead to chronic conditions such as headaches and back pain. In addition, female victims are prone to gastro-intestinal problems and are at risk for sexually transmitted diseases, urinary tract infections, fibroids, pelvic pain, and vaginal bleeding.[15, 19, 23, 27] Relevance of these data to IPV victims presenting to court venues is unclear despite the altered legal landscape over the past two decades to address IPV both civilly and criminally.

Some countries, including the United States, have responded by developing courts specifically designed to address matters of family violence. The development of IPV courts, such as integrated domestic violence courts, will continue to be of importance as other counties look to established courts for guidance. Court systems across the United States have addressed the issue of domestic violence as it impacts both criminal and civil aspects of the legal system. The New York State Court System has developed integrated domestic violence courts, where one judge hears all legal matters stemming from a common incident of domestic violence. The New York State Court System has reported positive results from the Integrated Domestic Violence Courts.[28] The implementation and continued development of Integrated Domestic Violence Courts is not limited to the United States and will influence the development of domestic violence courts worldwide.

The awareness of domestic violence issues in the legal setting has gained recognition world-wide. Canada, Australia, and the United Kingdom have also established specialized domestic violence courts. The Australian government has recognized the need to establish separate domestic violence courts to address issues, such as safety, faced by domestic violence victims when utilizing the criminal courts.[29] Specialized domestic violence courts have also been established throughout Canada. In Toronto a specialized court, known as the K court, was created to specifically address the issue of domestic violence. One survey of the K court emphasized the importance of coordination among parties and the value of learning from other established specialized domestic court systems.[30] A 2004 survey of the specialist domestic violence courts in England and Wales revealed many positive findings such as, increased efficiency, effectiveness, and increased public confidence.[31]

This paper reports findings from a study that describes mental and physical health symptoms among women presenting to family court seeking POs for IPV. This pilot study was conducted to assess IPV victims' physical and mental health needs, as well as insurance status, as planning steps for creating an on-site mental health clinic. In light of elevated medical and mental health morbidity observed among IPV victims in prior studies conducted in clinical settings, we hypothesized elevated medical and mental health morbidity compared to studies using population based samples of women.

Method

Setting

We recruited subjects from an upstate New York Domestic Violence Intensive Intervention Court (DVIIC) established in 1998. The DVIIC was the first civil IPV court in the state. To file a PO, at the time New York State law requires individuals be related by blood or marriage, divorced from or have a child-in-common with their perpetrators. The petitioner must have experienced one of six crimes enumerated under the Penal Code: harassment, disorderly conduct, assault (either misdemeanor or felony), stalking, or menacing. The State provides for concurrent jurisdiction permitting the victim the choice to file in family court, criminal court or both simultaneously (Family Court Act Article 8). Earlier pilot work demonstrated very little overlap between the two venues. [32]

The DVIIC issues POs to IPV victims when the facts of the case meet specific legal requirements that can be documented in the petition. Orders vary in duration and in some cases may not be warranted if the facts and injuries cannot be substantiated. The judges are hearing officers (some of whom are former Family Court judges) trained in the nuances of IPV; for example, they often provide temporary POs the day petitions are filed and schedule an appearance for both parties before issuing a permanent order, generally one week from the petitioner's first appearance. During that week, the respondent (against whom the order is being filed) is served notice and has the opportunity to appear before the Court and state his or her case. If the judge decides a permanent OP is warranted, court staff drafts and disseminates the OP in the courtroom so the petitioner will have it in hand before leaving.

All DVIIC petitioners were approached daily for a period of eight weeks, during the Court's morning calendar. We recruited subjects while they waited in a safe and locked waiting room separate from their alleged perpetrators. Recruiters worked in tandem with legal aid attorneys and battered women's advocates who have offices located in the waiting area and offer services to petitioners. As petitioners often wait 2 to 3 hours, we designed the study protocol to approach petitioners only after they had spoken with necessary court personnel and had received all necessary services in the waiting room from legal professionals and advocates from a local shelter. Over the course of the study, 170 petitioners were approached, and 109 (64%) completed the survey. The University of Rochester IRB approved all aspects of this study. This study was exempt and we did not document either legal case presentation or socio-demographic information for those who refused.

Instruments

Demographic Survey—The questionnaire assessed the subjects' age, gender, race, zip code, number of people in household, education, occupation, household income, and items pertaining to health insurance.

Short-Form-12 Health Survey, Version 2:[33–35]—This widely used instrument has two summary scales, the Physical Component Summary (PCS-12), which measures physical health and well-being by assessing an individual's physical limitations or abilities, and the Mental Component Summary (MCS-12), an index of mental health and well-being. Higher scores represent better health. The scales are well-validated and have national norms.[34,35] The Cronbach's Alpha for this study was .79. The Short Form Health Survey has been used widely with other domestic violence samples[36,37], however, this is the first known use with a court-based population, thus the need to cross-validate it with the General Health Questionnaire.

General Health Questionnaire:[38]—We also administered the GHQ to assess mental health and social functioning. The measure is a widely-used self-report measure designed to detect psychiatric disorders in primary care settings.[39,40] The GHQ has different versions with strong psychometric properties.[41] The GHQ-28, derived from factor analysis of the GHQ-60, consists of four subscales with seven items each. These include somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression. A higher score represents experiencing more psychiatric symptoms. Cronbach's Alpha in the current study was .94.

Results

The final sample for analysis included 95 female court-based petitioners with a mean age of 34 (s.d. 10.74). Table 1 depicts the socio-demographic variables for the sample. The racial distribution was 55 white (61%), 23 black (25%), and 12 other (14%). The educational level for the subjects was bi-modal with the majority of subjects having graduated from high school and having some college courses.

The SF12v2 findings are reported below in Table 2. The eight subscales are all weighted and comprise the two subscales (1998 national averages: mean=50, s.d. =10). All subscales' means fall below the national averages. The lowest scores are those indicative of mental health and social functioning. Subjects were assessed on whether PCS and MCS were correlated with any socio-demographic variables. Chi-Square was used to measure the correlations with age, race and education level. There were no significant correlations with any of those variables. In addition, having insurance and access to care were not significantly correlated with the two subscales.

On the GHQ, fifty-six subjects (52%) endorsed five or more symptoms, consistent with clinically relevant symptomatology. As with the SF12v2, there were no statistically significant correlations of age, race, education level, or access to care with the total GHQ score. As expected, the MCS and the GHQ were statistically significantly negatively correlated ($r=-.673$, $p<.001$), whereas the PCS and the GHQ were not significantly correlated ($r=-.023$, $p=.837$).

Seventy-nine subjects (88%) reported they would utilize such court-based mental health services if such services were available. Seventy-eight women (85%) had health insurance thus lending support for the implementation of an on-site mental health clinic.

Discussion

Given that the United States has turned to civil and criminal law to remedy what has been viewed as the "societal ill" of IPV [42, 43], courts may provide settings where it would be possible to develop an integrated arrays of services for ameliorating the mental health effects of violence. Many of the subjects of this study demonstrated clinically elevated symptoms, suggesting the need for mental health assessments and possible referral and treatment. Moreover, the large majority expressed a willingness to seek mental health care if it were offered at the court, suggesting the value of establishing court-based mental health services for IPV victims. While there has been a 254% increase in legal services to IPV victims between 1994 and 2000 in the United States[44, 45], there was only an increase of 39% in the volume of "counseling" services for IPV.[44, 45] Thus it also may be worthwhile to consider interdisciplinary training to help those in the legal field learn how to identify or selectively screen and refer individuals who demonstrate the need for mental health evaluations. Currently, many disciplines work in isolation. For example, despite one state's shelters reporting at least 25% of their clients had mental health issues [22], 54% of the shelters

reported fewer than a quarter of their staff members were trained on mental health issues. Only 23% had memoranda of agreement with local mental health centers to accept referrals of their clients.[22] It is likely that many more had interagency agreements with courts and police departments. IPV shelter workers frequently assist their clients seeking Ops in both criminal and civil court settings, health and housing benefits, and aid with short-term safety planning. Yet, they often are under or untrained to treat victims' complex mental health needs.[22, 46]

The reasons for this apparent disparity are complex given the consistent reports demonstrating the psychological and emotional toll of IPV. The fear of addressing the *"psychiatric"* needs of IPV victims may reflect the antipathy of many IPV advocates to any hint that victims might be in need of mental health services, understandably a reaction to past suggestions that sought to fault or stigmatize IPV victims with psychiatric labels. The dialogue to address IPV victims' mental health needs must begin in a context that does not blame the victim, while frankly understanding the need to further explore any links between being traumatized, suffering psychopathology, and safety-seeking behaviors.

At the heart of this dialogue lies the premise that women with clinically significant psychiatric symptoms may be greatly impeded from the benefit of myriad social and legal services now provided by both governmental and not-for-profit agencies. We must explore whether IPV victims' impaired functional status serves as a substantial factor limiting the utility of available services, many of which are specifically intended to enhance the basic safety of the victims themselves.

Limitations

It is important to consider the limitations of this first-generation study. These included small sample size, unclear generalizability to family violence courts in other regions or countries, and the cross-sectional nature of the data, which precluded drawing any causal inferences regarding the relationship between IPV and symptom complaints or indices of dysfunction. An additional limitation is the inability to document important information regarding those who refused and how this sample may be biased. It is also possible that the mental health burden is elevated by the court process itself, thus further support perhaps for an on-site clinic.[47] However, there also were several unique characteristics or strengths of this study, including the use of a court as a recruitment site, the safety of the setting, and the relatively high rate of subject consent to participate.

Conclusion

As victims of IPV may choose not to seek services from medical or clinical settings due to feelings of fear, shame, embarrassment, or guilt regarding IPV, screening and referring these victims in community-based settings to various services can be a next step for addressing the mental and physical health consequences of IPV, and for ultimately gaining greater personal safety. Despite increasing data regarding the psychological distress and psychiatric disease that intertwines with IPV, there has been no clinically-oriented randomized controlled mental health intervention trials that focus on IPV victims encountered 'outside' the traditional mental clinics or settings. Likewise, although the proliferation of IPV literature documents interventions, virtually nothing is known about the effects of interdisciplinary interventions to ameliorate IPV consequences through coordinated legal and mental health remedies. Such efforts can build upon prior service utilization studies demonstrating missed opportunities for mental health interventions[48], patients' perceptions of paths to treatment[49], and the need to integrate mental health services into other venues.[50] While courts seem a natural extension of the continuum of care, even court is a limited venue for some victims.

In some countries, cultural influences impact legislation and hinder the way IPV is handled in the court systems and may in fact exacerbate mental and physical health burdens. The patriarchal culture in India has created a challenging legal environment for IPV victims and many women do not have the resources to seek intervention.[51] Similar cultural trends are observed in Spain, where many women do not consider some forms of abuse, such as sexual assaults by a spouse, an act of domestic violence.[52] However, with courts becoming an extension of IPV intervention options, it is possible that these countries may eventually turn to the court system as well.

Clearly, many of the subjects in this initial court-based study merited careful assessments of their current mental health, and if warranted, expressed a willingness to engage in some type of treatment. Future research should explore further the utility of the courts as integrated care settings.

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Table 1

Sample Socio-demographics (n=95)

	Number	Percentage
Age	34 (s.d. 10.7)	
Race		
White	55	61%
Black	23	25%
Other	13	14%
Education		
No High School Degree	13	14%
High School Degree/GED	23	24%
Vocational Training	2	2%
Some College	31	33%
College Degree	18	19%
Post-College Training	3	3%
Graduate Degree	5	5%
Insurance		
Employer	43	47%
Self-purchased Insurance	3	3%
Medicaid	32	35%
None	14	15%

Table 2

SF12v2 Subscales and Aggregate Measures

Subscale	Mean	S.D.
Physical Functioning	40.28	13.42
Role Physical	47.09	10.74
Bodily Pain	44.99	12.27
General Health	48.67	12.48
Vitality	45.63	9.72
Social Function	39.14	13.05
Role Emotional	37.19	14.62
Mental Health	38.75	11.09
Physical Component Summary (PCS)	47.84	10.12
Mental Component Summary (MCS)	38.12	13.48