

Gender-based violence and women's mental health

How should the GP respond?

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Dealing appropriately with gender-based violence is a national priority and women often turn to their GPs first for recognition and assistance. Undisclosed abuse may be the cause of unexplained mental disorders and GPs should adopt an empowerment approach to encourage women to disclose the abuse.

Gender-based violence (GBV) includes, but is not limited to, physical, sexual, emotional and financial forms of abuse that are perpetrated by a current or past intimate partner (not necessarily cohabitating). Examples of GBV are rape, sexual assault and stalking. Victims are most commonly women and perpetrators are most commonly men.

Type and prevalence of GBV

In an Australian survey of 4451 women, more than one-quarter had experienced one of the common forms of GBV, namely rape (8.1%), other forms of sexual assault (14.7%), physical intimate partner violence (7.8%) and stalking (10.0%).¹ These figures have been confirmed by the Australian Bureau of Statistics Personal Safety Survey, which found that one in five women in

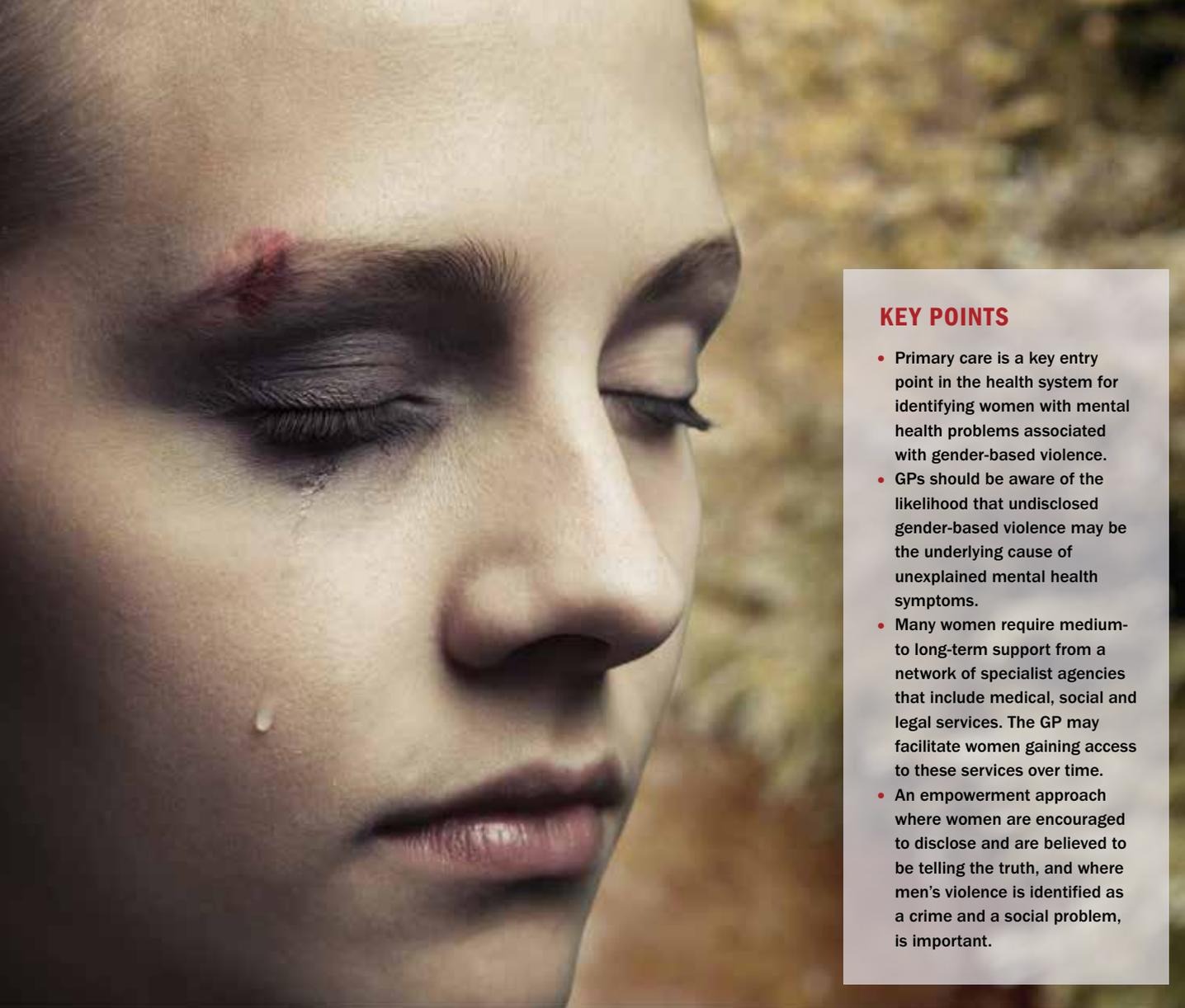
Australia have experienced violence at the hands of an intimate partner.² The risk of first exposure to GBV during childhood and early adolescence, especially for women, is extremely high. It has been shown that sexual assault and rape often occurred for the first time at an early age (median age, 12 and 13 years, respectively).¹

Association between GBV and mental health problems

There is a strong and consistent association between violence from men and common mental disorders among women in Australia.¹ Similar correlations have been identified in studies in both high- and low-income countries.³⁻⁶ There is a high incidence of first-onset mental disturbance among women within one to five years after exposure to GBV, compared with the onset of mental health disorders for a

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KEY POINTS

- Primary care is a key entry point in the health system for identifying women with mental health problems associated with gender-based violence.
- GPs should be aware of the likelihood that undisclosed gender-based violence may be the underlying cause of unexplained mental health symptoms.
- Many women require medium- to long-term support from a network of specialist agencies that include medical, social and legal services. The GP may facilitate women gaining access to these services over time.
- An empowerment approach where women are encouraged to disclose and are believed to be telling the truth, and where men's violence is identified as a crime and a social problem, is important.

matched sample of women who were not exposed to violence from men (Figure).⁷

The previously mentioned Australian study found that women exposed to one form of GBV (i.e. rape, other forms of sexual assault, physical intimate partner violence or stalking) had double the rate (58%) of developing a common mental disorder, including depression, anxiety disorder, post-traumatic stress disorder (PTSD), substance abuse or attempted suicide, compared with a rate of 27% among women who had not experienced GBV.¹ Both physical and psychological forms of GBV have significant adverse consequences for mental health.⁸ GBV is also strongly associated with disability, poor quality of life, unemployment and overall socioeconomic disadvantage among women survivors.

The relation between GBV and mental health is reciprocal: mental health problems

can follow experiences of GBV, but can also increase a woman's vulnerability to GBV. For example, GBV is correlated with disability and may limit a woman's capacity to maintain good health, sustain employment or gain formal education. As a consequence, the woman can become isolated, more dependent on the perpetrator and less confident in her personal capabilities, outcomes that in turn may increase her vulnerability to maltreatment.

Although major advances have been made in developing practice guidelines and policies aimed at preventing and responding to GBV in Australia, including guidelines from the Royal Australian College of General Practice (RACGP; Box),^{9,10} the association of GBV with adverse mental health outcomes has received inadequate attention, particularly in relation to presentations to primary care.

Screening for GBV among women with common mental disorders

Primary care is a key entry point in the health system for identifying women with common mental disorders associated with GBV. GPs should be aware of the likelihood that undisclosed GBV may be the underlying cause of unexplained mental health symptoms, particularly among women who attend repeatedly for assistance. In addition to overt symptoms of mental distress, women who have experienced GBV may have nonspecific physical symptoms such as headaches and abdominal problems for which a clear underlying pathology cannot be found.¹¹ Given the strong association, any assessment of a patient for depression or anxiety disorders should be accompanied by the recommended screening questions for GBV, which vary across states and territories.

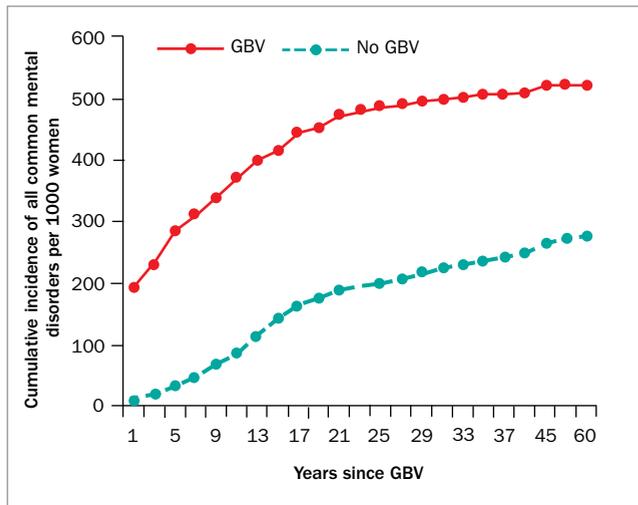


Figure. Survival curves showing cumulative incidence of all common mental disorders for Australian women exposed to gender-based violence (GBV) without previous mental disorder (n=929), compared with women with no exposure to GBV (n=3213).

Reproduced from: Rees S, et al. Onset of common mental disorders and suicidal behavior following women's first exposure to gender based violence: a retrospective, population-based study. *BMC Psychiatry* 2014; 14: 312.⁷

THE RACGP'S NINE STEPS TO INTERVENTION IN GENDER-BASED VIOLENCE – THE NINE RS¹⁰

The nine steps to intervention for GPs dealing with victims of gender-based violence are known as the nine Rs.

- Understanding your Role with patients who are experiencing abuse and violence
- Readiness to listen and be open to the patient
- Recognise symptoms among victims of gender-based violence, ask questions directly but sensitively
- Respond to disclosures of gender-based violence with empathic listening and explore the situation with the patient
- Risk and safety should be assessed and addressed
- Review the patient for follow up and support them
- Refer the patient to the appropriate specialist or support group
- Reflect on your own personal attitudes and management of victims of abuse and violence
- Respect your patients, your colleagues and yourself.

Breaking through the culture of silence

In screening for GBV, it is useful to be aware of the pervasive, albeit slowly changing, culture of silence about GBV and how this can hinder detection of the problem. Women may be unable to describe their experiences adequately, fear that they will not be believed, or that their disclosures will put them at risk of further abuse. If the GP can acknowledge the woman's experiences without hesitation and without asking for qualification, and can commit to working collaboratively to seek solutions, this is generally experienced as helpful and may allay these concerns. Socioeconomic disadvantage and marginalisation compound the problem of disclosure.¹¹ In particular, women with limited resources and few alternatives to their current situation are cognisant of the inadequate options they face if they leave a violent relationship or initiate this process by disclosing the problem to a health professional.

Women who are of Aboriginal or Torres Strait Islander background or who have been refugees may experience the

additional challenges of a distrust of authorities, isolation, discrimination and a stigma in seeking access to services. These factors can diminish personal confidence and reduce a woman's capacity to disclose GBV. GPs face the challenge of responding to the complex and diverse social and economic contexts in which women live and the impact of these on their capacity to form a trusting alliance with a healthcare provider.^{11,12}

Overcoming intimidation

Disclosure of GBV can be inhibited if partners or family members are waiting outside the consulting room. Men who are perpetrators of GBV can be particularly anxious and intrusive when women partners attempt to engage in confidential discussions with their medical practitioners. Women are correct to fear retaliation if, for some reason, their partner is alerted to the disclosure of GBV to others, including doctors. An important principle to remember is that women are at greatest risk of serious abuse and murder following a decisive attempt to end an abusive relationship.¹³

Protecting children and mothers

Women often harbour concerns that their children may be removed by authorities if they disclose violence in the family. GPs are mandated to report child abuse to the appropriate authorities, but their obligation to protect children needs to be conducted in the context of strong support for the mother. This includes participating actively in the intersectoral deliberations to ensure the parenting role of the mother is safeguarded in spite of her partner's violence. Concerns about risks of disclosure are best discussed openly with the patient as part of building trust and developing a pathway to an intervention plan.⁹

Avoiding labelling and overcoming victim blaming

Victim blaming, in which the woman is held responsible for her predicament, is a hallmark of GBV and is commonly the perpetrator's strategy or rationale. Women often internalise blame and form inaccurate views that in some way they deserve to be treated badly because they have failed to conform or behave as

expected. These cognitions can be amplified as their mood deteriorates and depressive thoughts about intrinsic unworthiness grow.

It is important to be sensitive to the impact of labelling as pathological a psychological state that is a normal response to this very traumatic and complex situation. To frame the woman's state of mind as a 'mental illness' can indicate to her that she is 'mad' (as often asserted by the perpetrator), and undermine the veracity of her account of abuse. Men who perpetrate violence can further undermine a woman's confidence, and increase her dependency on them, by claiming that the authorities will remove the children because she has been diagnosed with a mental disorder. Explanations that emphasise that the psychological symptoms are normal responses to severe adverse experiences are essential.

Intervening to assist women who have experienced GBV

Medical practitioners play a vital role in building a trusted therapeutic alliance with, and co-ordinating support for, women affected by GBV. The GP's role as advocate and counsellor is crucial, but usually not sufficient on its own. Many women require medium- to long-term support from a network of specialist agencies that include medical, social and legal services.¹⁴ The GP can help women gain access to medical care, the police, agencies to assist in the removal of perpetrators from the household, shelters, legal advice, financial assistance and support for at-risk children.

As all GPs will be caring for women who have had experiences of GBV, it is useful for them to be familiar with the current RACGP guidelines (Box)¹⁰ and to have referral processes in place that are specific to their location, context and

relation with GBV service providers. The importance of GPs being aware of and having links with services for women who have experienced GBV was highlighted in a recent study. It demonstrated that family doctors who had received systematic training in understanding and responding to GBV had greater capacity to detect and refer women to specialist services,¹⁵ and thereby potentially protect them from ongoing abuse and psychological distress.

Maintaining the doctor-patient relationship

Women referred to GBV-specific services may want and need to maintain a relationship with their GP so they can rely on the GP's continuing role in orchestrating and co-ordinating the inputs of all contributing agencies. The GP's sustained engagement during and after a woman's disclosure of abuse is crucial. An

empowerment approach, in which the GP provides factual information about the nature of this problem and its high prevalence in society, emphasises explicitly that women are never to blame for abuse. This type of approach, identifying the problem as socially constructed, can embolden women and increase their trust in the professional relationship.

Assisting with mental health needs requires an understanding of what is occurring in the life of the woman. She may be in the middle of a stressful legal battle, child protection authorities may be involved or she may be struggling to maintain her own employment while dealing with the impact of abuse. The risks of more severe mental health problems, drug or alcohol abuse and suicidal ideas or behaviours have to be considered.

Schedules and day-to-day demands can restrict the amount of time GPs have available to spend responding to the complex

factors impacting women experiencing GBV. Ideally, GPs need to feel sufficiently knowledgeable and skilled to be able to assess and respond to women experiencing GBV, and to engage actively with the multisectoral matrix of agencies that may be required. Further, while acknowledging time restrictions, it is important for GPs to keep detailed and systematic notes on the woman's physical injuries and forms of emotional abuse (such as belittling, humiliation or threatening harm to the woman or other family members) in the event that she may require them for future legal interventions. The GP plays an especially important role in identifying and responding to the adverse mental health effects of GBV, which may require referral of the patient to and liaison with a psychiatrist, psychologist or other mental health specialist.

In summary, the GP can have a pivotal impact in bringing about fundamental

change to the life-course trajectory of adversity associated with living with GBV. The overarching principles of an effective therapeutic alliance in this situation are to establish and maintain trust, to provide recognition and support and, using a solution-focused, stepped approach, to assist the women in her recovery from the impacts of GBV. The medium-term aim is to empower women to make the necessary changes, however difficult, that are required to promote recovery and resilience.

Considering the perpetrator's mental health

GBV affects more women than men and is an abuse of power by men.^{16,17} It often occurs where rigid gender stereotypes are held and where there are gender inequalities in relationships and in the wider society.^{16,18} Additional risk factors for becoming a male perpetrator of GBV include exposure to childhood neglect,

adversity and abuse, low self-esteem, alcohol and/or other substance abuse, and unemployment.¹⁸ Exposure to war trauma (e.g. among returning combat veterans) has also been implicated in male violence against women.¹⁹

If a GP becomes aware that a patient is a perpetrator of abuse there needs to be a clear value statement that it is the perpetrator's and not the victim's responsibility to stop the violence. It is important to be able to communicate clearly that violence against women is a crime, and that his abuse can be reported to authorities. Men's views about women's roles, rights and responsibilities can be challenged at the appropriate time.

Sensitive enquiry into the patient's childhood circumstances and experiences, current social stressors, employment situation, substance, alcohol and drug use, and past experience of family violence is important. It is also important to screen the patient for depression, PTSD and capacity to regulate anger and aggression.^{20,21}

Couple or family therapies are generally contraindicated as they carry the risk that patterns of abuse will be re-enacted and they are generally not effective.²² Although there is limited evidence to support it, the recommended approach is for male perpetrators of GBV to be referred to men's behaviour change groups. Australian states and territories offer a range of men's domestic violence behaviour change programs, including those aiming to address the use of violent and controlling behaviour, as well as anger management. These services are provided by government and non-government services, welfare groups and counselling programs. It would be useful for GP professional associations to gather and provide doctors with local information about the programs that are available, and to have referral pathways in place.

Conclusion

Dealing with GBV is now recognised as a national priority and this incurs costs for individuals, families, the economy and

society. Women generally turn first to GPs for recognition and assistance. Experiencing GBV is a clear risk factor for mental health problems and this abuse should always be assessed among women seeking care for mental health problems.

Women who have experienced childhood maltreatment or who are socio-economically disadvantaged, of Indigenous heritage, refugees or members of other marginalised groups may be especially vulnerable. In responding to disclosures of GBV and its mental health consequences, GPs should take an approach in which violence perpetrated by an intimate partner is named as a crime and a transgression of a woman's human rights. An approach that reflects violence against women as a systemic and not a personal failure will ensure that mental health problems will be perceived as an understandable response to adversity rather than an indication of individual psychopathology.¹¹ **MT**

References

A list of references is included in the website version (www.medicinetoday.com.au) of this article.

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