Intimate partner violence in deviant settings

Complex needs of women survivors

BACKGROUND
Women experiencing intimate violence within deviant settings, including bikie and other gangs and cults, have recently been the focus of research in South Australia. Domestic violence shelters are seeing increasing numbers of these women who are often involved in high risk behaviour and/or situations that pose significant risk to themselves and any accompanying children.

OBJECTIVE
This article provides an overview of the profiles of women (and their children) escaping intimate partner violence within deviant settings, and the range of complex physical and mental health needs medical practitioners are likely to encounter in these patients.

DISCUSSION
Specific women's histories of ritualised partner abuse, its cultural context, and the resultant physical and mental health issues for these women and their children is discussed. It provides strategies for practitioners to work with these women and their children to overcome existing barriers to clinical intervention.

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Intimate partner violence has implications for the health of women, children and their practitioners. It is estimated that general practitioners see up to five women per week who have experienced some form of domestic violence within the past 12 months.[1]

This article is based on the South Australian qualitative research project 'Best practice in working with women escaping violence'[2,3] and the literature around intimate partner violence. The research was undertaken in response to an identified need to address the difficulties domestic violence workers face in working with traumatised women survivors of intimate partner violence in deviant settings. Flinders University granted ethics approval for the project in January 2005.

We undertook a literature review of intimate violence. In the next stage of the research, workers from domestic violence shelters were asked to reflect on, or 'think aloud', about case files on practice issues that arose in working with women escaping violence. Ten workers from Adelaide domestic violence agencies provided information from 48 case files on women escaping bikie gangs, cults, or street gangs, and those experiencing sexual exploitation by providing 'sex for favours'. The research was necessarily retrospective. Researchers did not contact the agency clientele directly, as transience and fear of disclosure made this impractical.

Overall, 21 women were identified from the files as escaping violent bikie gang partners. Workers from one shelter advised that in a 12 month period, 16% of women seeking services were escaping bikie gangs and cults, and 14.5% were engaged in some form of sex work. Over a period of 14 months, 65 of 166 women accessing this shelter were homeless as a result of sexual violence.

Taped worker reflections were transcribed and analysed using the qualitative research software program (NVivo) to illuminate themes arising. This information was used to recommend development of practice strategies, interagency protocols, early intervention programs and service delivery, and to inform policy issues.

Defining domestic or intimate partner violence

The literature indicates that women subjected to intimate partner violence within the context of cults experience mind control and ritualistic sexual violence, or ritual abuse together with social isolation and mind control; and those with bikie gang connections are subjected to gross sexual practices with multiple partners in an environment of illicit drug taking and illegal activities.[4] This violence/abuse incorporates:

- domestic violence: 'an abuse of power. It is the

domination, coercion, intimidation, and victimisation of one person by another by physical, sexual or emotional means within intimate relationships'[5]

- ritual abuse: '...repeated abuse over a period of time, with physical abuse (that) is severe, sometimes including killing and torture. The sexual abuse is usually painful, sadistic and humiliating, and intended as a means of gaining dominance over the victim. The psychological abuse is devastating and involves the use of ritual indoctrination'[6]
- torture: '...the deliberate, systematic or wanton affliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason'.[7]

Cultural context of multiple abuses

The bikie gang is a cultural context for all forms of violence. Women gain entry to this subculture through social and sexual ties with one or more male members. Their place is to cater to gang members' demands, commonly in relation to sex work and drug making, taking and distribution.[4,8]

The South Australian research found that women escaping bikie gang partners faced other gang members' threats for breaching silence about illegal activities. As with cult members, these women believed it was impossible to escape – the gang 'owned' them and they were under constant surveillance. Women did not seek police protection as they were both victims and perpetrators of crime.[9]

Profiles

Both the literature and the South Australian research show that women experiencing intimate partner violence within cults and bikie gangs:

- face extreme physical and sexual violence, and emotional abuse[4,8]
- are often homeless[10]
- have physical and mental health problems[11]
- are addicted to prescription and illicit drugs,[12] and
- are often the primary carers of abused children.[9]

In addition, the South Australian research found histories of violence and abuse from childhood. These women experienced:

- high levels of violence as children
- current ritual abuse, gang rape and torture, and
- terror – a belief there was no escape.[9]

Violence against children

Children exposed to intimate partner violence are always abused, as they live within abusive environments. They experience the full taxonomy of abuse from exposure to it, to witnessing it, experiencing it themselves, and, in some cases, being forced to participate in it.[13] This may result in children exhibiting:

- sexualised and challenging behaviours
- learning difficulties (resulting in poor or no schooling)
- low self esteem
- anxiety and distress
- poor socialisation
- lack of trust
- threats to emotional attachment, and/or
- 'parentified' behaviours – role reversal in which children nurture adults.[14]

Mistreatment of children is a feature of intergenerational violence.[15] The greatest risk for becoming an adult victim of domestic violence is being female and having experienced abuse as a child.[16] Many child sexual abuse survivors will be sexually assaulted in adulthood through prostitution, early onset of sexual activity or multiple partners.[17] Childhood sexual abuse may lead to self harming practices. The majority of research subjects had been abused as children, and had children or adolescents who either accompanied them to shelters or were in foster care.

Complex physical and mental health issues

Many women in the South Australian study had major physical health issues, including:

- addictions (amphetamines and alcohol)
- significant risks around unprotected sex with multiple partners
- physical injuries – bruising and vaginal injuries
- self harm injuries, and
- fractures.[18]

Women's demeanours when presenting to the domestic violence shelter or agency included:

- emotional distress
- fear
- hypervigilance, and
- intoxication.[9]

These demeanours not only illustrated emotional distress, but also alerted GPs and allied health staff to challenges such demeanours posed; they are difficult to manage and present a possible impediment to successful intervention. In many cases it was difficult to get full histories from the women due to mental health problems, including:

- suicide ideation
- post-traumatic stress disorder
- bi-polar disorder, and
- personality disorders.

These women 'doctor shop' for prescription drugs, or referrals for injuries or mental health issues.

Special issues

Trauma/torture induced silence

While a traumatic event can occur at any time, prolonged and repeated abuse, such as that experienced by the women in the research group, occurs only under conditions of coercive control or 'captivity'.[19] Many women in the study were too afraid to tell their full story, refused medical help, and maintained contact with violent partners for fear of retribution by gang members, and fear of contact with the criminal justice system or mandatory notifiers in respect to child protection issues.

Mental health problems

Mental health problems were often combined with alcohol and illicit drug use, which also made it difficult to take a history. Fear led to fragmented histories and partial/unreliable recreation of dramatic situations they had left. In some cases, it led to complete evasion of questions.

Many women appeared to have undiagnosed mental illnesses and personality disorders. They were difficult to engage and assist on a long term basis and often employed face saving strategies to hide the reality of violence from social workers, GPs and others.[20]

Importance of 'finding a good doctor'

Domestic violence workers highlighted the importance of good relationships with women's health services, sexual assault services and GPs. The literature identified that some women are prepared to disclose intimate partner abuse to their GP, even with a range of identified barriers to disclosure.[21]

Vicarious traumatisation of practitioners

The potential effects of working with trauma survivors are distinct from other patient populations because of the worker's exposure to emotionally disturbing images of horror and cruelty.[22] Domestic violence workers in the South Australian study characterised their experiences as 'pushing the boundaries', 'all consuming' and 'affecting family life'.

Strategies for working with women escaping violence

The South Australian study identified the following three strategies for working with women and children escaping violence:

- provide emotional support to enable patients to 'open up' in a trusting environment
- refer patients to appropriate specialist services/support agencies, and
- work collaboratively with other support agencies (eg. domestic violence and crisis services, general health services, mental health and disability services, drug and alcohol services, indigenous services, counselling services, the criminal justice system, and child protection services), particularly in recording a full history of the patient's (and their children's) experiences of violence and abuse, and physical and mental health issues.

Conclusion

Medical and allied health practitioners need to understand what domestic violence/intimate partner violence means so they are aware of the trauma women and children experience. Practitioners also need to be aware of the complex physical and mental health issues linked to this violence such as mental illness, drug addiction and challenging behaviours. Practitioners need to obtain these patients' histories and recognise the high possibility of 'vicarious' traumatisation if they are to work positively and safely with them. Strategies for working with such patients provide basic guidelines for ensuring women and children traumatised by domestic/intimate partner violence receive the care they need.

Summary of important points

- Some forms of intimate violence may be defined as 'torture'.
- Practitioners need to:
  - view women and children who experience this violence as trauma survivors
  - be aware of the possibility of vicarious traumatisation
  - understand the culture of violence from which their patients come
  - be aware that patients use evasive strategies to hide violence.
- Main strategies for working positively with this group include:
  - emotional support
  - referral to specialist services, and
  - working collaboratively with multidisciplinary support services.

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References

1. The Royal Australian College of General Practitioners. Women and violence. South Melbourne: The RACGP, 2000.
2. Cooper L. Dilemmas in working with women with complex needs. Canberra: Department of Human Services, 2004.
3. Cooper L, Bowden M. Working with women associated with bikie gangs: Practice Dilemmas. Australian Social Work Journal 2006; in press.
4. Hopper CB, Moore J. Women in outlaw motorcycle gangs. Journal of Contemporary Ethnography 1999;18:363–87.
5. Australian Medical Association. Position statement on domestic violence. Canberra: AMA, 1998.
6. Los Angeles County Commission for Women. Ritual Abuse Taskforce Report 1989. Available at www.geocities.com/kidhistory/ra.htm [Accessed 8 August 2005].
7. World Medical Association. Declaration of Tokyo. Adopted by the World Medical Association, Tokyo, Japan 1975.
8. Wolf DR. The rebels: a brotherhood of outlaw bikers. Toronto: University of Toronto Press, 1991.
9. Cooper, L. Women escaping intimate violence. Report. Strategic Planning and Health Division, Department of Human Services, Government of South Australia, 2006.
10. Partnerships against domestic violence. Home safe home: the link between domestic and family violence and women's homelessness. Family and Community Services, 2000.
11. Breslau N, Davis G, Peterson E, Schulz L. A second look at comorbidity in victims of trauma: the post-traumatic stress disorder-major depression connection. Soc Biol Psych 2000;48:903–9.
12. Logan TK, Cole J, Leukefeld C. Women, sex, and HIV: social and contextual factors, meta analysis of published interventions, and implications for practice and research. Psychol Bull 2002;128:851–85.
13. Holden G. Children exposed to domestic violence and child abuse: terminology and taxonomy. Clin Child Fam Psychol Rev 2003;6:151–60.
14. Matsakis A. I can't get over it: a handbook for trauma survivors. Oakland: New Harbinger Publications, 1996.
15. Steele B. Child abuse: its nature and treatment. In: Noshfitz JP, Coddington RD, editors. Stresses and the adjustment disorders. New York: Wiley and Sons, 1990.
16. Roberts G, O'Toole B, Lawrence J, Raphael B. Domestic violence victims in a hospital emergency department. Med J Aust 1993;159:307–10.
17. West CM, Williams LM, Siegel JA. Adult sexual re-victimisation among black women sexually abused in childhood: a prospective examination of serious consequences of abuse. Child Maltreat 2000;5:49–57.
18. Stermac L, del Bove G, Addison M. Violence, injury and presentation patterns in spousal assaults. Violence Against Women 2001;7:1218–33.
19. Herman L. Trauma and recovery: from domestic abuse to political terror. London: Pandora, 2001.
20. Brady BM. America in crisis: mind control/ritual torture, battered women syndrome and family violence. The Journal of Family and Consumer Sciences 2000;92:17–20.
21. Hegarty KL. Barriers to disclosure of domestic violence in general practice. In: Women and violence. South Melbourne: The RACGP, 2000.
22. Steed L, Downing R. A phenomenological study of vicarious traumatisation among psychologists and professional counsellors working in the field of sexual abuse/assault. Australasian Journal of Disaster and Trauma Studies 1998;2.

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