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’²³ 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
Intimate partner violence within cults and research show that women experiencing women escaping bikie gang partners faced other perpetrators of crime. These women believed it was impossible to take a history.

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
- are often homeless
- have physical and mental health problems
- are addicted to prescription and illicit drugs, and
- are often the primary carers of abused children.

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.

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. 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.

Mistreatment of children is a feature of intergenerational violence. The greatest risk for becoming an adult victim of domestic violence is being female and having experienced abuse as a child. 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.

Vicarious traumatisation of practitioners

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.
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. 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