Should Programs Designed to Help IPV Survivors Screen for Mental Health–Related Problems: Voices From the Field

Catherine A. Simmons\(^1\), Matthew J. Delaney\(^1\), Leslie Lindsey\(^2\), Anna Whalley\(^3\), Olliette Murry-Drobot\(^4\), and J. Gayle Beck\(^1\)

Abstract
Qualitative responses that 187 service providers gave to a question assessing whether agencies designed to help intimate partner violence (IPV) survivors should screen for mental health-related problems were analyzed using a version of the concept mapping approach. Nine central clusters emerged from the data analysis, which can be linked to three underlying themes: how the identification of mental health-related problems (i.e., labeling) could be misused when working with IPV survivors, ways screening can be appropriately used to help IPV survivors, and barriers that prevent screening. Findings highlight the importance of trauma-informed approaches across all aspects of service delivery.

Keywords
IPV survivors, mental health, screening, domestic violence

Physical, sexual, and psychological abuse by an intimate (romantic) partner often occurs within the larger context of other lifetime trauma and stress, such as childhood abuse and community violence. Thus, it should be no surprise that women who suffer

\(^1\)University of Memphis, Memphis, TN, USA
\(^2\)Serenity Recovery Centers, Inc., Memphis, TN, USA
\(^3\)Shelby County Crime Victims Center, Memphis, TN, USA
\(^4\)Family Safety Center of Memphis & Shelby County, Memphis, TN, USA

Corresponding Author:
Catherine A. Simmons, Department of Social Work, University of Memphis, 226 McCord Hall, Memphis, TN 38152, USA.
Email: drcathysimmons@yahoo.com
intimate partner violence (IPV) are at an increased risk of developing mental health symptoms (reliving the traumatic event, hyperarousal, avoiding event reminders, depression, sleep disruption) that sometimes warrant diagnosable conditions such as depression, posttraumatic stress disorder, acute stress disorder, and anxiety-related conditions (Beck et al., 2014; Golding, 1999; Nathanson, Shorey, Tirone, & Rhatigan, 2012; Warshaw, Brashler, & Gil, 2009; Zlotnick, Johnson, & Kohn, 2006). When appropriate, mental health assessment, diagnosis, and treatment can greatly benefit this vulnerable population. Unfortunately, a conundrum exists in that diagnostic labels also have potential repercussions in court proceedings, custody arrangements, and interactions with the abuser. Together with limited service resources and the need to address pressing concerns such as housing and safety, many programs designed to help IPV survivors do not systematically/routinely conduct mental health screening (Simmons, Whalley, & Beck, 2014). Although these competing concerns seem apparent, very little empirical investigation is available to identify the opinions and concerns service providers have about screening IPV survivor clients for mental health–related conditions.

To address this gap in the professional literature, a needs assessment was conducted to better understand the opinions helping professionals (n = 325) have about screening for mental health–related problems and what (if any) resources would make doing so more relevant (Simmons et al., 2014). Findings from the quantitative portion of this study noted the following: (a) IPV helping professionals reported a high prevalence of mental health symptoms/concerns among their IPV survivor clients, (b) relatively few programs that work with IPV survivors routinely/systematically screen their clients for mental health problems, (c) most of the participants expressed a positive attitude about mental health screening despite the reality that most do not conduct such screenings, and (d) a need exists for resources to improve screening and referral options for IPV survivor clients who have mental health–related concerns (Simmons et al., 2014). Although the primary quantitative findings were published previously (Simmons et al., 2014), an interesting phenomenon occurred in which more than half of the participants (n = 187, 57.5%) chose to elaborate on the answer choice they selected for the close-ended question, “Should agencies designed to help IPV survivors screen for mental health–related problems?” Such an overwhelming response warrants further investigation. As such, the following study uses a modified concept mapping approach to present voices from the field about whether or not programs designed to help IPV survivors should screen their clients for mental health–related problems.

**IPV Helping Agencies**

Formal programs and services designed to help IPV survivors are relatively new phenomena that began with the early women’s movement. In 1971, Chiswick Women’s Aid, the first widely publicized shelter, opened in London, and in 1972 the first domestic violence crisis hotline started in St. Paul, Minnesota (Tierney, 1982). Generally staffed by IPV survivors and others directly affected by IPV, these early programs often viewed themselves as women-run spaces designed to help fellow IPV survivors/
victims find safety and rebuild their lives (Janovicek, 2007; Shostack, 2001; Tierney, 1982). As such, many of the people working in these early programs did not see themselves as mental health professionals but instead as peer helpers (Janovicek, 2007; Shostack, 2001; Tierney, 1982).

Since the inception of these early programs, a wide range of legal, faith-based, social service and grassroots organizations have developed resources and programs to help address the needs of women who have experienced IPV (Sullivan, 2000; Sullivan & Bybee, 1999). Striving to provide wrap-around services while ensuring continuity of support, many of the more recent helping organizations are staffed by individuals representing a wide interdisciplinary collection of allied professions. As such, they are able to address victims’ needs across multiple domains (physical, social, economic, legal, and emotional). Data suggest that use of such services helps IPV survivors to receive needed resources more quickly and effectively and to subsequently report a higher quality of life (Dutton, El-Khoury, Murphy, Somberg, & Bell, 2005). Although these organizations provide important services to IPV survivors, most are not designed to assess and/or address mental health concerns that often co-occur as a result of prolonged exposure to IPV (Simmons et al., 2014). Indeed, the professionals working in these programs represent a number of different allied professions including social work, psychology and counseling, administration, health professions, legal professions, paraprofessions, and the faith community. As such, many professionals working with IPV survivors are not trained to identify, assess, and/or treat mental health–related concerns (Simmons et al., 2014).

Elements of the Problem

Common mental health concerns documented among women IPV survivors include posttraumatic stress disorder, excessive generalized anxiety, depression, and substance abuse and dependence (Beck et al., 2014; Golding, 1999; Nathanson et al., 2012; Warshaw et al., 2009; Zlotnick et al., 2006). However, as stated previously, programs designed to advocate for IPV survivors do not systematically/routinely screen for mental health problems. A recent needs assessment documented some of the reasons for this, which included a need to focus on the immediacy of crisis needs and logistic concerns (i.e., time, money, personnel; Simmons et al., 2014). Indeed, some programs find community safety difficult to maintain when IPV survivors also present with multiple mental health, alcohol, and/or alcohol-related problems. Taken together, these reasons frequently prevent programs from doing more than is currently done. In addition, potential repercussions of diagnostic identification/labeling on the survivor/victim are a concern. Among the most salient are (a) discrediting the survivor with their family, friends, courts, and the police; (b) being used by the abuser to further manipulate and control; (c) reinforcing the abuser’s ability to rationalize their own abusive behaviors; (d) excluding the survivor from resources based on diagnosis; and (e) victim blaming. On the other side of this issue, equally real problems exist in that (a) exposure to ongoing trauma (such as prolonged abuse) increases the likelihood of mental health symptoms, and (b) mental health conditions appear to increase a
women’s risk of being abused (Briere, Woo, McRae, Foltz, & Sitzman, 1997; Goodman, Dutton, & Harris, 1997; Goodman, Johnson, Dutton, & Harris, 1997). In an effort to better understand the realities that arise in the field, the current qualitative study explores the following research question:

**Research Question 1:** Should agencies designed to help IPV survivors also screen for mental health–related problems?

**Method**

An online survey was administered to 325 helping professionals working in programs whose primary focus is serving the needs of IPV survivors. The survey included a variety of question types (yes/no, multiple-choice, multiple response, and open-ended). Among the questions asked was, “Should agencies designed to help IPV survivors screen for mental health–related problems?” As discussed below, four answer choices were provided followed by an open-ended space respondents could use to elaborate on their answer, if desired. More than half of the participants (n = 187, 57.5%) chose to provide a detailed explanation for their answer. The current project focuses on the qualitative responses provided to this question.

**Participant Recruitment**

A mixture of invitation and snowball sampling was used to recruit participants from social service, advocacy, legal assistance, and faith-based organizations with a primary mission to provide services to IPV survivors. In the first step of the process, professionals were invited to complete the survey via email addresses found on publicly available websites and listservs of various professional organizations. From these original invitations, snowball sampling was then used to broaden the sample. Snowball sampling is a form of chain sampling where study participants recruit additional participants from among their acquaintances (Rubin & Babbie, 2010). To accomplish the second step, participants were asked at the end of the survey to forward the link to their colleagues. In one instance, an organization that received the original email posted the survey on the “help wanted” section of their website. This sampling method was selected to ensure anonymity of respondents and also achieve representation from a wide range of professionals working across the United States. To prevent duplication of responses, the survey program did not allow multiple surveys to be completed from the same Internet Protocol (IP) address.

**Participants**

Participants for the original study include 325 professionals working in organizations that provide support for IPV survivors across the United States (including Washington, DC) and the U.S. protectorates. Data for the present study included a subsample (n = 187, 57.5%) of participants who provided qualitative responses to the question
“Should agencies designed to help IPV survivors screen for mental health–related problems.” No significant demographic differences were found between the participants who chose to elaborate on their answer and those who did not ($p > .05$).

Ages of the participants who chose to give a narrative response to the question ranged from 24-72 years with a mean age of 46.71 years ($SD = 12.34$). The sample was very well educated, which is expected for a study targeting professionals. All of the participants were high school graduates ($n = 187, 100\%$), while most indicated they had a bachelor’s degree or higher ($n = 168, 89.8\%$). Participants also had considerable experience working with IPV survivors with an average of 12.24 years ($SD = 8.58$) and a range from 0-37 years. See Table 1 for further demographic characteristics.

Data Analysis via Modified Concept Mapping

A version of the concept mapping approach to data analysis was selected for this project because it synthesizes qualitative data into a quantitatively structured diagram. Based on the work of Trochim and colleagues (Jackson & Trochim, 2002; Kane & Trochim, 2007; Trochim, 1989a, 1989b), concept mapping has been used for research in the areas of public health (Burke et al., 2005; Trochim, Cabrera, Milstein, Gallagher, & Leischow, 2006), mental health (Johnsen, Biegel, & Shafran, 2000), study abroad programs (Poole & Davis, 2006), and program evaluation (Kane & Trochim, 2007).

The concept mapping process used for this study consists of five distinctive stages where qualitative data are reduced and sorted into meaningful categories. In the first stage, responses to the selected survey question were divided into units of analysis with each unit consisting of only one concept (Jackson & Trochim, 2002). In the second stage, eight people (coders) representing a variety of educational and professional backgrounds independently sorted these units of analysis into meaningful groups. From the sorting process, a matrix was created for each coder using a binary code grid with cell values representing “whether (1) or not (0) a pair of statements was sorted by that coder into the same pile” (Jackson & Trochim, 2002, p. 315). The individual grids were then combined into a larger matrix with cell values representing the number of coders who combined the respective concepts (units of analysis). In the third stage, multidimensional scaling analysis using the proxscal algorithm was conducted on the larger matrix using the computer program SPSS. Multidimensional scaling finds the structure in a set of proximity measures by “assigning observations to specific locations in a conceptual low-dimensional space such that the distances between points in the space match the given (dis)similarities as closely as possible” (Multidimensional Scaling, n.d., p. 1). The result graphically shows how different objects of comparison do or do not cluster based on a series of similarity or distance judgments made by the sorters in Step 2 of the concept mapping process. During multidimensional scaling, a type of perceptual mapping takes the form of a scatterplot. The stability of these scatterplots is reported using (a) the stress value that ranges from 0.0-1.0 with 0.0 indicating a perfect goodness of fit and (b) the Dispersion Accounted For (DAF: correlation between factors) that ranges from 0.0-1.0 with 1.0 indicating a perfect solution. In the
fourth stage, individual points on the scatterplots (the units of analysis) were grouped together into final cluster solutions using hierarchical cluster analysis of the data points identified by multidimensional scaling. Hierarchical cluster analysis is a form of cluster analysis that uses agglomerative methods to arrange the elements (units of analysis) into clusters using a hierarchical tree structure. The process begins with each individual element/unit in its own cluster, then iteratively merges them in successive
intervals until there is only one cluster. Thus, using this method, the researcher must decide the number of clusters based on the degree of detail desired. For purposes of the current study, the number of clusters was based on (a) the degree of similarity of the included constructs, and (b) the proximity between clusters on the perceptual map. In the fifth stage, clusters were labeled/named based on the central idea of the group cluster, recommendations of the sorters, and the best judgment of the six-person research team. In the sixth and final stage, the resulting answer clusters were then linked to (a) the multiple response answer choices provided by the respondent, and (b) the respondent’s professional affiliation.

Results

To address the research question, participants were asked, “Should agencies designed to help IPV survivors screen for mental health–related problems?” and were provided with four multiple-response answer choices and an open-ended space to elaborate on their answer. Analyses of the multiple response answer choices is summarized as follows; yes, most certainly \( (n = 67, \ 35.9\%) \); maybe, it depends \( (n = 94, \ 51.9\%) \); no, absolutely not \( (n = 20, \ 10.7\%) \); and I have no opinion \( (n = 6, \ 3.2\%) \). Qualitative responses were analyzed using the previously described modified concept mapping approach. Of the 187 responses included in this study, 23 contained multiple detailed yet unrelated ideas. Thus, these responses were divided into between two and five parts/concepts resulting in 221 distinct concepts analyzed. Multidimensional scaling (PROXSCAL procedure) revealed a stable solution (normalized raw stress = .0347; DAF = .9653) after 23 iterations. Hierarchical cluster analysis then revealed nine distinct clusters. Central themes for each cluster were heuristically identified using information provided by the original eight coders and the six-person research team. The resulting perceptual map is illustrated in Figure 1 and detailed below. The answer clusters were then linked to (a) the multiple response answer choices displayed in Table 2 and detailed below and (b) professional affiliation displayed in Table 3 and detailed below.

Cluster 1

Labeled “Training to Address Client Needs,” the first cluster consisted of 37 responses highlighting a belief that professionals conducting mental health assessments need further training to better help, and not harm, IPV survivor clients. Ideas included in this cluster focus on the need to train professionals on ways to (a) reduce the potentially harmful effects of the assessment process, (b) avoid adverse results of labeling, (c) obtain client consent, (d) make sure assessment processes are conducted within the agency mission, and (e) identify follow-up needs. To illustrate, one participant wrote, “Not if it’s going to label them forever” while another wrote, “I do believe that we would need training on how to best administer the screening.” Similarly, one participant wrote,
assessment sound like an interrogation or a screening-out process). Often times, PV/DV/SA agencies are the only source of comfort for a lot of women, and to make those organizations too rigid would be a disservice to its clientele.

**Cluster 2**

Labeled “Concern About Pathologizing DV Responses,” the second cluster consists of 50 responses highlighting concerns about inappropriately labeling responses to IPV pathology when they are actually normal/expected reactions to violence/abuse. Among these concerns are that the staff lacks education/training about trauma response and that most programs provide services to IPV survivors when they are in a crisis mode (i.e., just left the relationship or are still in the relationship making decisions about their future). From the included responses, there is a concern that labeling “normal reactions” as pathology could damage victims emotionally, psychologically, and socially. To illustrate, one participant wrote, “Victims in crisis mode don’t need to be ‘labeled’ as having mental health issues as well. The abuser has probably told them that over and over.” A second participant wrote,

Many behaviors expressed by women who experience IPV are a result of the abuse rather than of mental illness. It may not always be in the best interest of a woman to be screened...
Table 2. Cross Tabulation Table Linking Participants’ Responses to the Multiple-Choice Option to the Cluster in Which Their Narrative Response Was Sorted.

<table>
<thead>
<tr>
<th>Cluster 1. Training to address client needs</th>
<th>Multiple-choice response</th>
<th>Yes, most certainly</th>
<th>Maybe, it depends</th>
<th>No, absolutely not</th>
<th>I have no opinion</th>
<th>Total within 9-cluster model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 2. Concern about pathologizing DV responses</td>
<td></td>
<td>1.4% (1)</td>
<td>30.7% (35)</td>
<td>3.7% (1)</td>
<td>0% (0)</td>
<td>16.7% (37)</td>
</tr>
<tr>
<td>Cluster 3. Trauma symptoms are common</td>
<td></td>
<td>1.4% (1)</td>
<td>25.4% (29)</td>
<td>66.7% (18)</td>
<td>33.3% (2)</td>
<td>22.6% (50)</td>
</tr>
<tr>
<td>Cluster 4. Screening can be beneficial but . . . limits</td>
<td></td>
<td>10.8% (8)</td>
<td>6.1% (7)</td>
<td>7.4% (2)</td>
<td>0.0% (0)</td>
<td>7.7% (17)</td>
</tr>
<tr>
<td>Cluster 5. Positive aspects of screening</td>
<td></td>
<td>4.1% (3)</td>
<td>14.0% (16)</td>
<td>14.8% (4)</td>
<td>33.3% (2)</td>
<td>11.3% (25)</td>
</tr>
<tr>
<td>Cluster 6. Screening would be helpful to make appropriate referrals</td>
<td></td>
<td>51.4% (38)</td>
<td>9.6% (11)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>11.1% (49)</td>
</tr>
<tr>
<td>Cluster 7. Continuity of care is essential</td>
<td></td>
<td>9.5% (7)</td>
<td>1.8% (2)</td>
<td>0.0% (0)</td>
<td>16.7% (1)</td>
<td>4.5% (10)</td>
</tr>
<tr>
<td>Cluster 8. Barriers to resources: victims, agencies, and communities</td>
<td></td>
<td>14.9% (11)</td>
<td>4.4% (5)</td>
<td>0.0% (0)</td>
<td>16.7% (1)</td>
<td>7.7% (17)</td>
</tr>
<tr>
<td>Cluster 9. Although screening could be helpful, we have to focus on different things</td>
<td></td>
<td>6.8% (5)</td>
<td>7.0% (8)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>5.9% (13)</td>
</tr>
<tr>
<td>Total within four-item response choices</td>
<td></td>
<td>0.0% (0)</td>
<td>0.9% (1)</td>
<td>7.4% (2)</td>
<td>0.0% (0)</td>
<td>1.4% (3)</td>
</tr>
</tbody>
</table>

Note. Column percentages are based on four-item multiple-choice response options. $\chi^2(24, N = 221) = 147.964, p < .000.$
Table 3. Cross Tabulation Table Linking Participants’ Professional Affiliation the Cluster in Which Their Narrative Response Was Sorted.

<table>
<thead>
<tr>
<th>Professional Affiliation</th>
<th>Administrator</th>
<th>Legal profession</th>
<th>Paraprofessional</th>
<th>Pastor, Rabi, or other spiritual leader</th>
<th>Professional counselor</th>
<th>Social worker</th>
<th>Advocate/activist</th>
<th>Health care profession</th>
<th>Total within cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster 1</td>
<td>24.3% (9)</td>
<td>8.1% (3)</td>
<td>2.7% (1)</td>
<td>0.0% (0)</td>
<td>8.1% (3)</td>
<td>45.9% (17)</td>
<td>10.8% (9)</td>
<td>0.0% (0)</td>
<td>100.0% (37)</td>
</tr>
<tr>
<td>Cluster 2</td>
<td>18.0% (9)</td>
<td>2.0% (1)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>22.0% (11)</td>
<td>28.0% (14)</td>
<td>28.0% (14)</td>
<td>2.0% (1)</td>
<td>100.0% (50)</td>
</tr>
<tr>
<td>Cluster 3</td>
<td>11.8% (2)</td>
<td>5.9% (1)</td>
<td>5.9% (1)</td>
<td>0.0% (0)</td>
<td>5.9% (1)</td>
<td>41.2% (7)</td>
<td>29.4% (5)</td>
<td>0.0% (0)</td>
<td>100.0% (17)</td>
</tr>
<tr>
<td>Cluster 4</td>
<td>20.0% (5)</td>
<td>4.0% (1)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>12.0% (3)</td>
<td>28.0% (7)</td>
<td>36.0% (9)</td>
<td>0.0% (0)</td>
<td>100.0% (25)</td>
</tr>
<tr>
<td>Cluster 5</td>
<td>14.3% (7)</td>
<td>2.0% (1)</td>
<td>2.0% (1)</td>
<td>0.0% (0)</td>
<td>16.3% (8)</td>
<td>46.9% (23)</td>
<td>16.3% (8)</td>
<td>2.0% (1)</td>
<td>100.0% (49)</td>
</tr>
<tr>
<td>Cluster 6</td>
<td>10.0% (1)</td>
<td>0.0% (0)</td>
<td>10.0% (1)</td>
<td>0.0% (0)</td>
<td>30.0% (3)</td>
<td>30.0% (3)</td>
<td>20.0% (2)</td>
<td>0.0% (0)</td>
<td>100.0% (10)</td>
</tr>
<tr>
<td>Cluster 7</td>
<td>23.5% (4)</td>
<td>5.9% (1)</td>
<td>0.0% (0)</td>
<td>5.9% (1)</td>
<td>35.3% (6)</td>
<td>11.8% (2)</td>
<td>11.8% (2)</td>
<td>5.9% (1)</td>
<td>100.0% (17)</td>
</tr>
<tr>
<td>Cluster 8</td>
<td>23.1% (3)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>23.1% (3)</td>
<td>30.8% (4)</td>
<td>23.1% (3)</td>
<td>0.0% (0)</td>
<td>100.0% (13)</td>
</tr>
<tr>
<td>Cluster 9</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>100.0% (3)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>100.0% (3)</td>
</tr>
<tr>
<td>Total within professional affiliation</td>
<td>18.1% (40)</td>
<td>3.6% (8)</td>
<td>1.8% (4)</td>
<td>0.5% (1)</td>
<td>17.2% (38)</td>
<td>36.2% (80)</td>
<td>21.3% (47)</td>
<td>1.4% (3)</td>
<td>100.0% (221)</td>
</tr>
</tbody>
</table>

Note. $\chi^2(56, N = 221) = 58.398, p = ns.$
for and subsequently labeled with a mental illness, especially if the behaviors used to label her are responses to abuse.

A third participant wrote, “We are law enforcement based, crisis services, it may not be the most appropriate time in some cases to screen for mental health issues when there are urgent safety concerns.” A fourth participant wrote, “While formal diagnoses can be helpful for treatment and referrals, it can sometimes create problems with legal battles, particularly custody cases. Sometimes it exacerbates problems in CPS cases when their personnel are not trained mental health professionals.”

**Cluster 3**

Labeled “Trauma Symptoms Are Common,” the third cluster consists of 17 responses highlighting the idea that screening IPV survivors for mental health concerns/symptoms would be beneficial if it leads to treatment (trauma-informed care). Within this cluster are concerns about misdiagnosing symptoms in which trauma symptoms are common and “normal” in the IPV survivor population. To illustrate, one participant wrote,

> Mental health–related problems experienced by victims of IPV are usually mountains the victim must climb before being able to move forward. These mental health problems are usually a result of the victimization. Victims need to address all issues that may complicate their progress to recovery. Making mental health counseling and services available through referral can only help the victim become a survivor.

A second participant wrote, “Not to label but to assist survivors in understanding the impact of IPV and assisting them in developing ways to cope and heal.” A third wrote, “A screening should consider trauma informed care.”

**Cluster 4**

Labeled “Screening can be Beneficial but . . . Limits,” the fourth cluster consists of 25 responses identifying the practical limitations that reduce the benefits of screening. Among these limitations are (a) the length of contact with the client is often short, (b) the type of contact the professional has with the client is often not conducive to screening, (c) trauma-informed care is needed, (d) the tools we have are not trauma informed, and (e) the trauma responses seen within this population are often misunderstood. To illustrate, one participant wrote,

> Our clients are here at our safe shelter from a few days to a couple of months. Many who come to us experiencing violence in their lives are dealing with many issues all at once. It is hard for us to get them all addressed when time is of the essence and do not always have enough time to help them the way they need help.

A second participant wrote, “On the other hand, we do work with victims who are struggling with undiagnosed mental health issues and may benefit from earlier
identification and treatment. However, I worry that current tools are not trauma informed.” A third participant wrote, “We apply a strengths-based non-pathological approach. Often, clients believe they have mental health issues, but once trauma reactions are explained and normalized based on their experience the client realizes they do not have a mental health issue.”

Cluster 5

Labeled “Positive Aspects of Screening,” the fifth cluster consists of 49 responses highlighting the benefits of screening IPV survivor clients for mental health–related problems/concerns. These include the ideas that screening for mental health conditions (a) is an opportunity to enhance services for the client, (b) could increase the professional’s/program’s ability to make appropriate referrals, and (c) should be conducted because many IPV survivor clients need appropriate intervention to improve. This third idea about clients needing intervention was further elaborated with discussion about how trauma symptoms look different in this population. To illustrate, one participant wrote, “. . . without screening, individuals will have a higher likelihood of falling victim again.” A second participant wrote, “Good assessment equals good intervention and also helps women understand their constellation of symptoms. It empowers them with language and with knowing that there is hope, they are not crazy, and that they can feel better.” A third participant wrote,

It is my belief that mental health assessment tools can help therapists to better understand the complex emotional and personality presentation of victim/survivors of IPV. Perhaps welcoming them (assessment tools) into treatment will compel a better understanding of the profile(s) that abused women might present to then better inform the profession.

A fourth participant wrote, “If it is to enhance services or to make an appropriate referral, then our agency should screen clients for mental health–related problems.” A fifth participant wrote,

Mental health distress and IPV are naturally interconnected. We find it beneficial to screen for mental health–related issues so that we can support women better in our groups and refer to community partners when needed. It also opens the door for us to normalize some of women’s struggles with trauma, depression and anxiety in the context of partner violence. Seems we have an opportunity to place individual challenges in context of oppression . . . and reduce shame/blame along the way.

Cluster 6

Labeled “Screening Would Be Helpful to Make Appropriate Referrals,” the sixth cluster consists of nine responses indicating the helpfulness of screening to the referral process. To illustrate, one participant wrote,

We seek to provide comprehensive services that address all of a client’s needs. If a client has needs we are not equipped/trained to address, we refer them to other community
resources. Our clients can’t become safe, healthy, and self-sufficient if they are suffering from undiagnosed/untreated mental illness.

A second participant wrote, “If a client has mental health needs that we cannot address we refer them to a mental health professional. We are not counselors and it is imperative that we get our clients the treatment/care that they need.”

**Cluster 7**

Labeled “Continuity of Care Is Essential,” the seventh cluster consists of 17 responses elaborating on the need for cooperation between providers and clients to ensure the highest quality care is provided. To illustrate, one participant wrote,

I believe that the general screening we utilize at our agency works for us and for our clients. If we believe that a client is having symptoms that are causing a disruption in everyday life, are inhibiting her from functioning, or causing her more grief than usual (as reported), we refer the client to be formally assessed for mental health–related problems.

A second participant wrote, “I automatically (informally) screen every client I see for mental health and substance abuse issues.” A third participant wrote, “We have MSW counselors on staff that we refer participants to if we feel that they need counseling or if the participant requests it. I am not familiar with how the screening process is implemented within that department.”

**Cluster 8**

Labeled “Barriers to Resources: Victims, Agencies, and Communities,” the eighth cluster consists of 13 responses highlighting the barriers that get in the way of appropriate screening. Among these barriers are (a) professional licensure, (b) lack of or limited agency resources, and (c) insufficient funds/money to pay for services at the victim, agency and community level. To illustrate, one participant wrote,

The issue we have is the services available in this area are nil. And then the victims do not always have a way to get where they need to be. [For] example [not attending] appointments due to not having insurance or transportation and we have no public transportation.

A second participant wrote, “They don’t have the tools or the health care insurance to be able to address these issues appropriately, nor do we have the tools, time, or budget to address issues appropriately.” A third participant wrote, “Cost is also often an issue.”

**Cluster 9**

Labeled “Although Screening Could Be Helpful, We Have to Focus on Different Things,” the ninth cluster consists of three responses highlighting the idea that most
programs that serve IPV survivors concentrate on other things (e.g., safety, legal matters, immediate needs). Indeed, mental health concerns are not the primary focus of most professionals dedicated to helping IPV survivors. To illustrate, one participant wrote, “Our agency does not screen for mental health–related problems, however if we could send clients to a place that does, it would help our clients greatly . . .” A second wrote, “. . . Our job is to support the survivor. It could be helpful in terms of a longer relationship or if it meets survivor needs.”

**Links to the Multiple Response Answer Choices**

Illustrated in Table 2, responses participants gave to the original close-ended question were linked to the nine cluster responses. Using a simple cross-tabulation, the differences noted in this table are not likely due to chance, $\chi^2(24, n = 221) = 147.964, p < .000$. From this referent, it is important to highlight some of the findings. Most of the participants who responded “no, absolutely not” provided details that linked to Cluster 2 (66.7%, concerns about pathologizing DV responses). Similarly, most of the participants who responded, “I have no opinion,” provided details that linked to Cluster 2 (33.3%, concerns about pathologizing DV responses) or Cluster 4 (33.3%, screening can be beneficial but . . . limits). Inversely, most of the participants who responded, “yes most certainly” provided details that linked to Cluster 5 (51.4%, positive aspects of screening). Finally, the narratives provided by participants who responded, “maybe, it depends” were predominately linked to Cluster 1 (30.7%, training to address client needs) and Cluster 2 (25.4%, concerns about pathologizing DV responses).

**Links to Professional Affiliation**

Illustrated in Table 3, respondents’ professional affiliations were linked to the nine cluster responses. Using a simple cross-tabulation, the differences noted in this table did not meet significance, $\chi^2(56, n = 221) = 58.398, p = ns)$. Further z-score analysis did not identify column differences when considering either the professional affiliation or the coded cluster. Thus, findings for the current sample indicate similarity of coded responses across professional affiliations.

**Discussion**

The current study reported the qualitative findings from an online survey designed to better understand the opinions IPV helping professionals have about screening survivors for mental health–related problems. Using a modified concept mapping approach, nine central clusters emerged which can be linked to three underlying themes. The first theme encapsulates ideas related to how the identification of mental health–related problems (i.e., labeling) could be misused when working with IPV survivors (Clusters 1, 2, and 3). The second theme connects ways screening can be appropriately used to help IPV survivors (Clusters 4, 5, 6, and 7). The third theme identifies barriers that prevent screening (Clusters 8 and 9). The idea that trauma-informed care is essential is
a common thread linking the positive and negative aspects of screening IPV survivors for mental health–related problems. Interestingly, analysis linking the clusters that emerged to the respondent’s professional affiliation did not identify differences. Such findings could indicate the ideas expressed by the respondents represent concerns universally identified across the diverse range of professionals dedicated to ending IPV and helping IPV survivors.

**Harmful When Inappropriately Used**

The first three clusters that emerged draw attention to ways the identification of mental health–related problems could be inappropriately used and harmful to IPV survivors (114 of the 221 total units of analysis). Most of the respondents who indicated “no absolutely not” to the original close-ended question (77.7%) provided narrative that sorted into one of the first three clusters. Although the origin of these concerns is outside the scope of the current study, it is possible that historical and social ways mental health diagnoses have been misused contribute to the concerns noted. Historically, across numerous populations, concern has been noted about how diagnostic labels create unnecessary stereotypes in which not all people with the particular diagnosis necessarily fit (Czechowsky, 2009; MacCulloch, 2010; Rosenhan & Spitzer, 1998). In court cases involving women IPV survivors, this oftentimes results in the exclusion of relevant testimony that could help determine the actual issues (Biggers, 2005; Wells, 2012). Similarly, the abuser could use the stigma associated with their victim’s diagnosis to control and discredit the IPV survivor. Diagnostic labels have the potential to reinforce the abuser’s ability to rationalize their own abusive behaviors (e.g., because she’s “crazy,” I had no choice . . .). Indeed, asserting that abuse accusations are delusions, lies, or otherwise unreal is a key component of the coercion, power, and control used by abusers (Pence & Paymar, 1993; Shepard & Pence, 1999; Stark, 2007). It may be for this reason that so many respondents of the original study chose to provide narratives qualifying their responses in the first place. It may also explain why the clusters link to the “no absolutely not” answer choice (77.7%).

**Helpful When Appropriately Used**

The second theme to emerge identifies ways helping professionals can appropriately use screening to help IPV survivors (101 of the 221 total units of analysis). The four clusters are connected by positive opinions IPV helping professionals have about screening their survivor clients for mental health–related problems. More than half of the responses in these clusters (57.4%) straightforwardly identify the positive aspects of screening. Among these benefits are (a) opportunities to enhance services, (b) the ability to improve referral activities, and (c) the acknowledgment that to improve their functioning, many IPV survivor clients need help with their mental health–related problems. However, two of the clusters acknowledged the need to overcome practical limitations that reduce the benefits of screening. Some of these limitations include (a) the length and type of client contact, (b) recognition that trauma responses seen within
this population are often misunderstood, and (c) the need for trauma informed screening tools and treatment/care approaches. Finally, the importance of cooperation between providers and clients to ensure continuity of care was highlighted. As part of this cluster, participants indicated they already assess for mental health–related problems, however they do it “informally and our way . . .” (A. Whalley personal communication, January 2014).

Trauma Informed Care

Linking the positive and negative aspects of screening IPV survivors for mental health–related problems is the fact that trauma-informed care is essential. Trauma-informed care is an approach to working with clients that acknowledges the role trauma has played in their lives (Huckshorn & LeBel, 2013). For IPV survivors, these traumatic experiences compound over time and include the betrayal of a trusted person, their intimate partner. For most IPV survivors, this includes a loss of safety and recurring iterative feelings of disconnection, isolation, guilt, shame, rage, and isolation. Thus, without approaching intervention from a trauma-informed care approach, one cannot know what is actually being identified. One way to conceptualize many of the behaviors displayed by clients could be as an expected reaction to traumatic experiences. These ideas are scattered throughout the responses, regardless of cluster. These issues include (a) the appropriate use of diagnosis for guiding treatment and (b) not misusing diagnosis/diagnostic information for harming the client. Indeed, there is a need for agencies to implement best practices that incorporate trauma-informed models and do not increase client risk through stigma and labels. Further empirical inquiry is needed to develop, assess, and implement service delivery options that balance the consequences that arise with diagnostic labels with the equally real difficulties related to mental health symptoms/problems when working with IPV survivors.

Limitations

It is important to note a number of limitations inherent to the current study. First and foremost, the study is a qualitative exploration in which objectivity is neither assumed nor expected. The qualitative narratives analyzed were broad and subjective in nature. Data analysis methods were intended to inductively create areas for further exploration and theory generation. Thus, by definition, the findings of the current study are highly subjective. Further research is needed to determine whether the findings are generalizable to the greater population of professionals working with IPV survivors and, subsequently, to the survivors themselves. Second, the large amount of content participants provided to the open-ended response option presents a double-sided opportunity. On one side, the sizable number of respondents who expounded on their answer indicates this is an important concern that warrants acknowledgment and investigation. Indeed, the large number of participants who gave an explanatory statement in response to the yes/no question demonstrates the interest in and the importance of this issue within the professional field (i.e., it is a strength). On the other side,
reducing the 221 concepts (14 pages of narrative) into a manageable number of related concepts undoubtedly results in a loss of detail. Thus, some important ideas could have been inappropriately reduced and/or otherwise lost in the process. Although such concerns are unavoidable in qualitative data analysis, it is an important limitation to highlight when considering the findings of the current study.

A third limitation is that the two-part sampling method used for this study makes it impossible to know how many people received the survey or to follow up directly with respondents. However, because participants represented a range of professional affiliations and demographic backgrounds, the diversity of the sample provides support for representativeness appropriate to the study purpose. Fourth, and similarly, the type of helping agency was not controlled for in this study. Although all of the participants work for programs dedicated to ending IPV and helping IPV survivors, professional backgrounds represent a wide range of services. Thus, perception about needs would also be different. Future research should focus on mapping attitudes toward mental health screening with specific types of settings to discern specific needs. Additional research exploring issues of generalization could be useful; for example, are there differences between professional affiliations with respect to the acceptability of mental health screening within social service environments?

Closing Thoughts

Despite the limitations of the current report, the findings provide valuable insight into areas where further training is needed, ways to make mental health screening more appropriate for IPV survivors, and factors that may limit the ability of IPV survivors to receive care for mental health conditions. The study also highlights the need for more information about ways that mental health screening tools can be applicable to work with IPV survivors and mechanisms to help IPV survivors receive care for mental health conditions when needed. However, even if there are appropriate tools available, there appears to be a lack of resources available to serve this population. As funding trends move from shelter-based services to criminal justice-based services, it seems money is moving away from transitional services that include counseling/treatment for trauma-related symptoms. Perhaps, hopefully, these trends might change and focus more resources on trauma-informed approaches. This, in turn, may remedy the concerns about less-than-optimal available mental health care and emphasize the benefits of screening IPV survivors for mental health–related symptoms/problems.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.
References


Author Biographies

Catherine A. Simmons, PhD, LCSW, is an associate professor at the Department of Social Work, the University of Memphis. Her research interests revolve around trauma and violence with a focus on family violence and strengths-based interventions. Her publications include two books and more than 30 professional articles focusing on social work practice issues. She has
more than 20 years of social work experience with family violence, trauma, and mental health populations. Currently, she teaches clinical practice and research courses in the graduate program.

Matthew J. Delaney, MSW, is a recent graduate of the University of Memphis, College of Social Work. He completed his BA in psychology at Auburn University. He has extensive experience working as a behavior therapist with children on the autism spectrum as well as a medical social worker with terminally ill patients. He plans to acquire LCSW and BCBA credentials post-graduation.

Leslie Lindsey, LMSW, is a counselor at Serenity Recovery Centers, Inc., Memphis, Tennessee. While a graduate student, she worked as a graduate clinician and researcher with the Athena Project at the University of Memphis, Department of Psychology. Her primary research interests include intimate partner violence and trauma. Previous work has included the promotion of HIV/AIDS sexual safety for survivors of domestic violence, community-based participatory action research, and urban youth development initiatives.

Anna Whalley, MSW, LCSW, is the Administrator of Crime Victim Services for the city of Memphis and Shelby County. She has 33 years experience working with victims of family violence within the low income, urban setting of Memphis, Tennessee.

Olliette Murry-Drobot, MBA, MA, is the executive director of the Family Safety Center of Memphis and Shelby County. She has more than 14 years of professional experience as an administrator working in the social services. Currently, her primary focus is collaborative efforts to help victims through the services of help available in Memphis and Shelby County.

J. Gayle Beck, PhD, is professor and the Lillian and Morrie Moss Chair of Excellence at the University of Memphis, Department of Psychology. He is an internationally regarded expert in the areas of posttraumatic stress disorder, treatment development, and experimental psychopathology with extensive experience working with women who experienced intimate partner violence.