Choices
MENTAL HEALTH CENTER

Disorders of Intimacy
(Domestic Violence)

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OVERVIEW OF THE PROBLEM:

The FBI estimates that one woman is beaten by her husband or partner every 15 seconds in the United States (U.S. Department of Justice, Federal Bureau of Investigation, 1988). Every year, 2 to 4 million women in the United States are battered by a partner (Horton, 1992). According to the U.S. Department of Justice, Office of Justice Programs, 1 in 5 women who had been victimized by a partner or ex-partner had been the victim of three assaults within a six-month period (Harlow, 1991). A 1990 study by the Colorado Department of Health reports that incidents of domestic abuse among disabled women may be as high as 85 percent. Disabled women are also vulnerable to sexual assault (National Center on Women and Family Law).

More than 1 million women seek medical assistance for injuries caused by battering each year (U.S. Department of Health and Human Services, 1991). Twenty-eight percent of women who come to an emergency department with injuries due to domestic violence require admission to the hospital, and 13 percent require major surgical treatment; one-third of these attacks involve a weapon (Berrios and Grady, 1991). Eighty percent of abused women report their injuries to medical personnel on at least one occasion and 40 percent seek medical attention on at least 5 different occasions (Morrison, 1988). Abused women are more likely to seek help from their physicians than from lawyers or police officers (Mehta and Dandrea, 1988). Forty percent of

assaults on women by their male partners begin during the first pregnancy; pregnant women are at twice the risk of battery (Martins, et al., 1992). Abused women are twice as likely NOT to begin prenatal care until the third trimester (McFarlane et al., 1992).

According to the Nebraska Domestic Violence and Sexual Assault Commission, an estimated 43 percent of battered WOMEN NEVER TELL ANYONE. (Nebraska Commission on the Status of Women, 1991).

It is clear that while an enormous amount of resources are required to provide care and safety for those women who come to the attention of the authorities, neither the full force of the law nor the work of various committed advocacy groups have been able to provide a systemic fundamental long-term remedy for this critical public health hazard.

The availability of appropriate laws and statutes mandating the police to arrest batterers, the willingness of the District Attorneys to prosecute and the judges to issue orders of protection have resulted in exposing the complex, multi-determined reality along with the insufficiency of our conceptualization of the problem.

While it is clear that in respect to the cases that come to the attention of Victim Services the courts and other agencies, women's fear for their own and their children's safety play a central and motivating factor in their seeking help, fear is not the only emotion requiring attention. Intense rage, the tenacity with which the aggressor remains involved with the victim and vice versa, the ambivalence and shame exhibited by the victim when the question of pressing charges and testifying against the abuser is raised, must all be taken into account when devising a more effective strategy against the physical and mental health devastation caused by abusive patterns of

interaction among intimates.

Contrary to what may be expected, resorting to physical aggression in navigating the intense emotional arena of intimate relationship does not create a sense of power and effectiveness in the aggressor. Both the intimidating party and the frightened victim experience a sense of powerlessness and misery. The aggressor is often full of remorse and the victim apprehensive and baffled. It is clear to both parties that a frighteningly significant event has taken place, but both try to deny its importance, to promise that it will never happen again, to blame it on too much alcohol, too much pressure at work, a terrible misunderstanding, and so on. It is rarely, if ever, viewed as a symptom of a potentially malignant process in their relationship.

At times, the first slap or punch, etc. may indeed be the only occasion that the loss of control occurs, but the more likely scenario is that of repetition and escalation of destructive behavior, sometimes ending in such catastrophic events as homicide and suicide.

Unlike other acts of violence, the goal of the aggressive act among intimates is not to create distance but to bind and enmesh. The flight of the victim is not experienced as a victory by the aggressor but a further affront. Total submission and virtual enslavement of the victim to the aggressor does not appease but seem to enrage even further. Indeed, most often, the aggressor does not hide when the enormity of abuse is obvious to all, but promises to continue to follow, stalk or harass his tormented victim even as he is convinced that he is the one being tormented and or abused. It is reported that seventy-nine percent of spousal abuse is committed by men who are divorced or separated from their wives (Harlow 1991).

The unique characteristics of psychological and physical battering between intimates indicate that the behavior pattern must be viewed as a disorder of an interpersonal relationship that is

reinforced and validated by cultural and political norms. Bio-psycho-social factors as well as historical, cultural and economic issues play an important motivating role in all individual behaviors including aggression. Personal relationships are played out against and through a socio-political background that validates traditional gender differences and power differentials. The cultural roles of man/woman husband/wife partner/lovers have within them the seeds of potential conflict and abuse.

Societies over evaluation of males and their resulting sense of superiority and entitlement gives them a false sense of adequacy and self sufficiency which is sorely challenged when confronted with the difficult task of navigating interpersonal situations. Concurrently, socialization of female children imbues them with the expectation of being taken care of, led and cherished by men, and thus, unequipped to deal with partners who make irrational demands, isolate, intimidate and torment them. The added sense of being responsible for the health and longevity of the relationship as well as believing that "everything will turn out right if I just do the right thing"--disenables many women from developing an adequate sense of autonomy and agency.

As it has become clear that good intentions and mutual attraction do not guarantee the success of intimate relationships, it is necessary to identify the skills needed to negotiate this emotionally charged arena and to provide counseling when the earliest signs of problems appear. Various social agencies and institutions can educate and make appropriate referrals, physicians can ask and identify symptoms of destructive interactions and offer help long before the first slap or punch--or before the only available avenue of intervention or help is through the criminal justice system.

DISORDERS OF INTIMACY PARADIGM

Choices Mental Health Center's *Disorders of Intimacy Paradigm* has been developed to address the treatment needs of couples involved in patterns of interactions that could and often do lead to violence. C.M.H.C. is committed to addressing the range of needed therapeutic interventions to prevent and reduce the incidence of what has heretofore been labeled "domestic violence". To that end, C.M.H.C. has developed a theoretical framework applicable to multi-ethnic, multi-cultural, heterosexual and same sex partners which allows us to provide treatment for the individual and/or the couple depending on the dynamics, needs and abilities of the parties involved.

C.M.H.C.'s short-term, focused, treatment model has been designed after extensive clinical experience and a thorough review of research in the area. There have been many and various theoretical constructs defining the etiology and treatment of domestic violence. Historically and currently these theories have been viewed as conceptually mutually exclusive or politically adversarial, resulting in a general failure to effectively address the escalation of the problem. C.M.H.C.'s eclectic approach allows intervention on various points of the cycle of abuse and maltreatment in order to prevent the onset of physical violence as well as prevent its escalation and reduce harm when it has occurred.

Our program is designed to address the political and psychological aspects of the problem without further re-victimizing the victim of violence--or demonizing the abuser. It is well known

that there are indeed women who continue to stay in abusive relationships because there are positive emotional and psychological bonds. Others stay because they feel their lives would be further endangered if they leave. We will not further shame and victimize the woman who wants to maintain her relationship. On the other hand, we will not cast the abuser in the role of a pariah. We believe there are victimizers who want to and can be helped to change.

C.M.H.C. has reframed and renamed the issue of domestic violence as *Disorders of Intimacy* in order to address the continuum of abuse and the need for harm reduction strategies. As a misguided communication strategy between couples, violence must be addressed in the context of their relationship.

Choices Mental Health Center treats:

the **batterers** who need to be removed from the home and be in treatment before any possibility of reconciliation takes place (if this is desired);

the **batterers** who can acknowledge their unacceptable behavior and can respond positively in couples counseling;

the **victims**, some of whom have successfully left violence behind them and some of whom find themselves leaving one abusive relationship for another; and

the **couples**, men and women and men and men and women and women who find themselves bound to one another in spite of the violence.

C.M.H.C. will also treat the **families** who have been impacted on by the violence.

No one strategy can hope to treat the dysfunction represented by disorders of intimacy. It is our responsibility to help maintain the emotional integrity and physical safety of the victim, continuously acknowledge the responsibility of the batterer and when present, support the couples desire to remain together. All of this is done in collaboration with the law enforcement and court

system as well as broader community supports when available.

In order to end the violence in the home, treatment can be with the victim, the batterer and/or the couple. The following will address the Referral Process, Intake and Assessment Process, the Treatment Modules and Assessment.

REFERRAL PROCESS:

Referrals to the Choices Mental Health Center can be accepted from the courts, therapists, hospitals, social service agencies, H.M.O.s, public hospitals and physicians. Individuals referred to Choices Mental Health Center can be mandated or non-mandated clients. The basis for ongoing collaboration is established with the referral agency or individual. When mandated by the courts, the mutuality of goals, i.e. to prevent further violence is discussed with the client. A feedback mechanism is put in place by which the court can get periodic assessments regarding the level of participation and perceived progress of change. The client is informed of the nature of the feedback and the relationship between therapy and the legal system. The issues involved with violent behavior is also clarified.

The client is given an appointment within 5-7 working days for an intake and assessment. Clients must be covered by insurance, Medicaid or be able to afford a sliding scale rate for services.

INTAKE:

Regardless of the form of treatment, **intake information is gathered separately.** The individuals are assessed first and then the relationship. General intake procedures ascertain a description of the client including:

A- mental status,
B- the presenting problem and history of the problem,
C- current living situation and family situation,
D- previous psychiatric and medical history,
E- history of substance abuse, physical or sexual abuse or neglect,
F- legal history and current status

Additional issue information is obtained, including:

For the batterer, specific information related to his/her perception of the problem/ battering, it's triggers, escalation pattern, the object of the abuse, i.e. child, adult, repeated partners, and what has been attempted before to control the abuse, if anything.

For the victim, specific information related to his/her perception of the problem/ battering, it's triggers, escalation pattern, and what has been attempted before to control the abuse, if anything.

Both the batterer and the victim are asked to define their goals for treatment. In addition, for the batterer, the level of acknowledgment and acceptance of responsibility is assessed and for the victim the level of acknowledgment and/or denial regarding the pattern/impact of abuse is assessed.

ASSESSMENT:

Couples are seen in conjoint treatment when they present the following:

- At the time of treatment, no violence has occurred.

- If there has been violence, the batterer is a willing participant in treatment.

- Both have the same or parallel treatment goals.

- If patient exhibits active psychosis, the patient must be in treatment.

- If there is any alcohol or drug abuse, patient must be in or entering treatment for the abuse.

- Both the victim and batterer are willing to commit to a reduction of violence and to the primacy of safety for the victim.
- Both are willing to accept the use of legal restraints if the abuser is unable to control the the violence.
- The current level of violence is not such that the victim appears to be or feels she/he is in imminent danger.

If a couple is not appropriate for conjoint treatment therapy; Individual and group therapy is available to both, in order to enhance:

· their coping skills

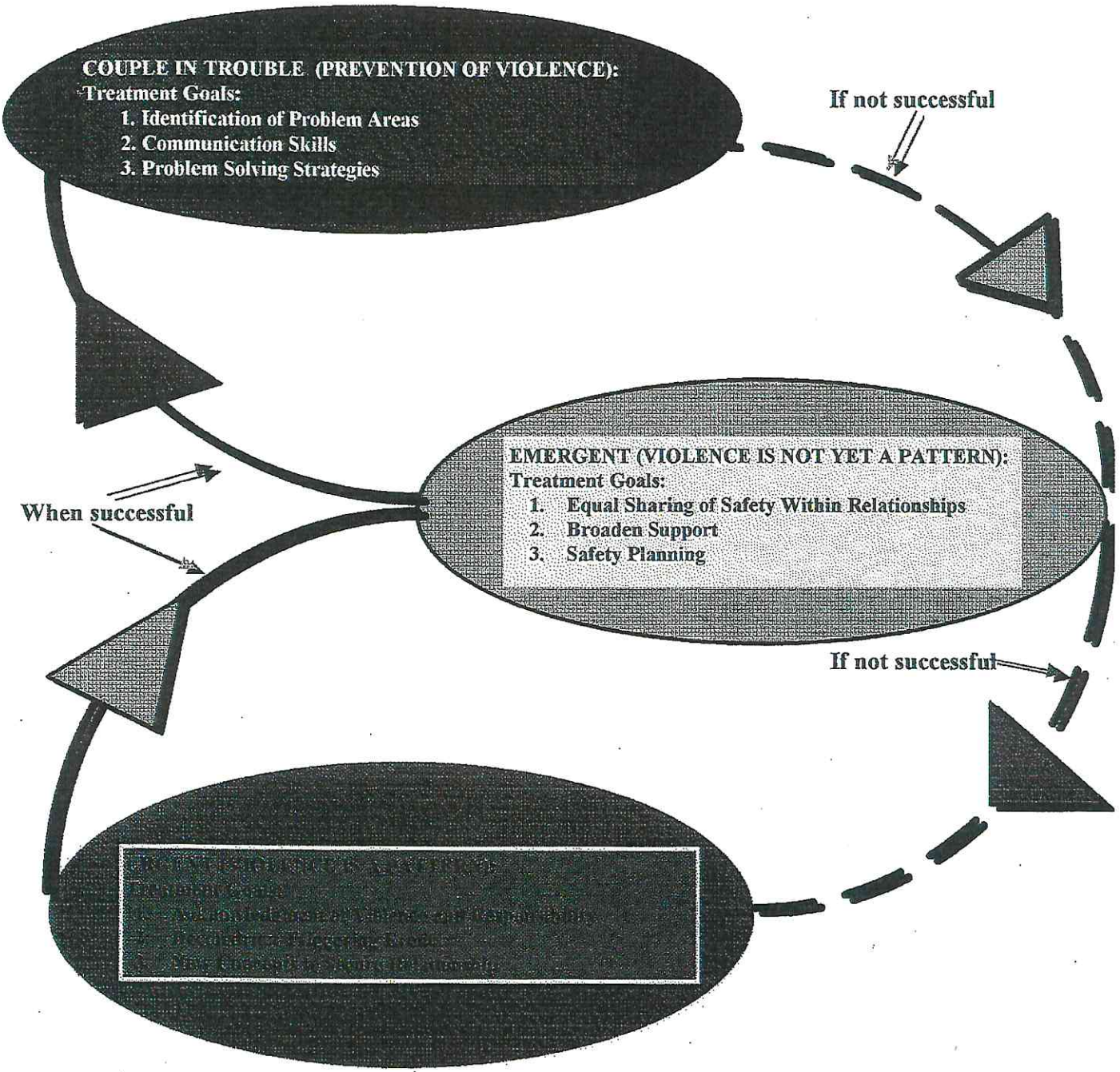
· the development of insight into their role expectations

· communication and behavior with the goal of reduction of violence

· increased motivation for change.

Since the trigger event or events bringing individuals and couples to treatment vary widely, i.e. first incidence of violence, first order of protection, inability to hide the abuse from others, C.M.H.C. has developed a circle of disorder which identifies three points of intervention enabling the identification of treatment goals based on evaluation and assessment rather than the trigger event.

PREVENTION TREATMENT MODEL



Both victims and victimizers may need a broad range of treatment modalities to be opened to them...individual, group and conjoint. Some can be in two modalities at the same time, i.e. group As well as conjoint. Others may need to be in individual before conjoint counseling, while others may need to be in individual during conjoint treatment.

Choices Mental Health Center has developed a model that provides a conceptual frame of reference for the therapist and fosters a sense of clarity and mastery to the patient. By providing clear guidelines and spelling out the underlying assumptions, the module defines the manner in which it is best utilized.

HARM REDUCTION MODEL FOR TREATMENT OF FAMILY VIOLENCE (DISORDERS OF INTIMACY)

The "Harm Reduction" model of counseling in families with intimacy disorder is based on the following premises:

1. **With few exceptions individuals are responsible for their behavior and its consequences.**
2. **Individuals who live together, prefer to do so in a non-destructive and nurturing environment regardless of their reasons for remaining together.**
3. **Aggressive and destructive behavior by one or more members of a household is injurious to the health and well-being of all members.**
4. **Violence is a dead end street from which all parties desire to exit.**

This model is designed to give a conceptual frame of reference to the therapist and foster a sense of clarity and mastery to be transmitted to the patients. The high level of specificity and well delineated goals distinguish the model from other efforts attempting to increase communication or promote insight. Furthermore, the same set of principles are applied in individual and group therapy modules and as such the two modalities reinforce each other. Because of the multiplicity of individual dynamics played out in the family arena and the social and cultural factors dictating the function of families, no one strategy can hope to treat the

dysfunction represented by family violence. By providing clear guidelines and spelling out the underlying assumptions, the module defines the manner in which it can be best utilized.

APPLICATION:

1) The 12 session module described here may be introduced in its entirety with the recommended sequence when both members of the family are motivated to change or when following individual treatments for each, the family has achieved the level of harmony which allows them to work towards the common goal.

2) As the second stage module for individual treatment plan after evaluation and assessment phase for the victim and the perpetrators.

3) As a supplemental module to individual counseling for group therapy for both victims and perpetrators.

The module uses a cognitive-emotive-behavioral frame of reference to identify:

a) maladaptive cognition;

b) the emotional dynamics of the choice of violence in intimate interactions; and

c) the destructive consequences of the behavior for participants and the non-participant members.

The educative and problem solving approach is flexible and individualized in order to achieve maximum effect by being sensitive to socio-cultural and personal factors operating within the family.

The length of session is dependent on the use that the module is put to. Individual sessions last 40 to50 minutes, while conjoint sessions may require an hour and a half.

Role of Therapist: The role of therapist in this module is to act as a clarifier of confused emotions, to help formulate poorly articulated ideas, to identify maladaptive and erroneous cognition and destructive behavior patterns. While respecting differences in cultural and social backgrounds, the therapist must remain committed to the notion that violence in intimate relationships is destructive to all involved and contrary to the survival and the well-being of the connections between individuals and the health of the family.

In joint or group session it is imperative to refrain from inferences and interpretations and limit one's intervention to clarification and restatement or reformulation of what is being said and to act as a sensitive and emphatic moderator, not allowing one individual to monopolize the session or add several negative statements to the partner without the opportunity for response.

Furthermore, the therapist must remain task oriented in spite of the many occasions in which the immediate crisis may require attention and patients may feel more at ease with emotional catharsis about the latest hurt rather than an exploration of the underlying problems in their lives.

SESSION 1

A) Brief introduction by therapist regarding the ground rules of conjoint or group session;

1) taking turns to talk and listen, 2) no verbal and or physical threats, 3) walking out of the session only as the last resort, 4) returning to the session as soon as the individual

feels in control, 5) the importance and necessity of doing the assigned "homework".

B) The therapist introduces the first key concept that violence among intimates is a way of communication. It is therefore necessary to explore what is being said and why this language is selected to say it.

C) Patient(s) is asked to choose from the list messages encoded in the violent act and to add his/her own. Some of the more common messages are:

I need you and must control you for my own security.

I have power over you, and you do not acknowledge that.

You are trying to take power away from me.

I am powerless and frustrated.

You do not respect me.

You hurt me, you hurt my pride.

I will show you how to respect me.

I want to prove that you need me, that you are powerless.

I want to get back at you because you have betrayed me, disillusioned me, disappointed me, humiliated me, tied me down.

I cannot trust you unless I can see that even when I abuse you, you stay with me.

D) In conjoint or group session the therapist tries to identify the field of meaning shared by members of the group or the two partners in conjoint therapy. For example, the initiator of a violent act endorses the statement "I need you" as a possible message---the partner disagrees strongly. Conversely the aggressor indicates disbelief when the partner takes the message as

"I will show you how powerless you are."

At the close of the session the therapist will assign "homework" to be brought to the next session. Partners are instructed to recollect examples of past conflict situations exemplifying the agreed upon messages.

SESSION 2

A) Following a brief greeting, the therapist asks each partner for a report of his/her respective "homework" as the subject for discussion.

B) The therapist identifies the points of common perception and disagreement regarding the meaning and the significance of the given interactions.

C) The most recent conflict is discussed on the basis of the meaning of the message and the outcome of the interaction.

D) The assigned "homework" is used to recollect examples of situations similar to the most recent conflict in which the outcome had been different and the possible causes for these differences.

SESSION 3

A) The therapist asks for the reports regarding the "home work" and maintains the goal of helping individuals decipher the meaning of their communication, even if the inter-session events seem to require urgent consideration. It is important to resist the temptation of crisis resolution and crisis management in order to avoid fragmentation and dissipation of attention and to encourage in-depth examination of the pattern and significance of the

behavior.

B) No home work is given in this session in order to underline the importance of the key concept discussed during the previous sessions.

SESSION 4

A) The therapist introduces the second theme of the therapeutic exploration; the reason(s) for the choice of violence to deliver the intended message.

The individual is hopelessly inarticulate.

He/she believes that the partner does not understand any other way, will not listen or will deny the significance of a message differently delivered.

The pair have implicitly agreed that this is the surest and quickest way to communicate.

The aggressor acknowledges that anger rules his/her life and he/she is lacking self-control.

The aggressor believes that he/she will not get any consideration if partner is not intimidated and fearful.

The aggressor views his/her behavior as assertiveness.

The aggressor views his/her violence as revenge or self-protection.

B) The therapist tries to explore and clarify each theme and elicit pertinent information regarding the statement which has been accepted or endorsed as the possible reason for the violent interactions.

C) The "home work" assigned is to describe the communicative aim and value of the most serious fight that has ever taken place between the couple.

SESSION 5

A) The report of the home work will open the session with the goal of identifying factors responsible for the choice of violence and the message embedded in it.

B) The therapist helps identify such cognitively dysfunctional beliefs as equating assertiveness and strength with violence, or obedience based on fear and intimidation as respect.

C) Issues relating to self-control and lack of communicative skills are discussed in this session.

D) Aggravating factors such as drinking, drugs, children's educational and/or behavioral problems, problems with in-laws, jealousy and sexual problems are specifically asked for and discussed. (Some of these issues may require more detailed discussion in private. Members of conjoint or group therapy must be given the opportunity to do so in individual sessions.)

SESSION 6

A) Discussion during this session begins with the theme of direct and forthright communication.

B) Therapist introduces the concept of barriers to direct communication. Among possible obstacles are:

Fear of consequences, rejection, humiliation, loss of face, loss of status.

Desire to devalue the partner by acting as if he/she is not intelligent enough to understand, does not have the capacity, will not know how to respond.

Shame over one's own emotions: I am too dependent, I am too much in love, my lust has enslaved me, I cannot take care of myself, I let him/her control my life.

Guilt: I am not worthy of love, I don't want to mislead anybody, let him/her see what kind of person I am.

Individuals are asked to choose those statements which best describe their feelings or the feelings of their partner and add others which may be more relevant.

C) The assigned "home work" for each individual is to formulate a way that she/he would indicate disagreement, love or dependency needs to another person if he/she did not fear rejection, humiliation, loss of autonomy, loss of power and loss of face.

SESSION 7

A) The therapist reviews the three key concepts which have been covered so far, namely: violence as a communication strategy, the reason for the choice of violence as a way to deliver a message, and barriers to direct communication.

B) Reports of the homework are discussed applying these three concepts. In group or conjoint sessions each member is encouraged to listen to the description and perception of the others and to offer opinions and ideas or solutions when a problem is identified.

C) "Homework" for this session is for the patient or each member of the pair or the group to keep a record of all fights or serious conflicts during the week. This may be in the form of written accounts, a few sentence reminders or verbal description.

SESSION 8

A) The therapist asks for the home work; the most serious of the encounters are selected for describing the manner in which it began, the members of the family who were present at the time, the manner in which the fight terminated and how long it continued.

B) The remainder of the session is devoted to a detailed analysis of the issues raised by this encounter. The understanding of the cause or causes, the message, the possible effect of the presence of others, the impact on others, the amount and nature of physical and psychological hurt and injury, the manner of its termination and the aftermath.

SESSION 9

A) Discussion of the homework and further clarification of the issues.

B) Elements of reconciliation. The therapist asks the patient(s) to enumerate the reasons for reconciliation and clarify for the pair what it is that binds them together.

Financial security, emotional bonds, loyalty, desire for sex, need for money, need for shelter. Fear of loneliness, fear of retaliation, harassment, stalking. Fear of rejection by family, friends, community, loss of employment, children, animals, loss of status, loss of social standing or prestige, loss of life, legal complications.

C) The assigned homework is to eliminate as many causes of reconciliation as can be managed in any other way and to bring only those which remain unresolved.

SESSION 10

A) The therapist asks for the results of reflection on causes of reconciliation on the part of the patient(s), and ascertains that all other solutions to the needs motivating reconciliation have been considered.

B) The therapist helps the patient to articulate the perceived need and desire for the continuation of the relationship, exploring any remaining doubts and ambivalence.

C) The therapist helps the patient to identify those aspects of the relationship which must change in order to significantly reduce or eliminate the continuous harm and the possible danger of the relationship.

D) The assigned homework is a list of actions and strategies which had temporarily minimized or aborted a violent and negative encounter in the past.

SESSION 11

A) The therapist asks for the list of strategies used and tries to identify each as to whether placating, distracting, withdrawal of attention, walking away, threat of abandonment, threat of exposure, call to the police, or any combination of the above have been effective. How long the effectiveness lasted and whether any threat was actually carried out.

B) The therapist helps the patient(s) identify the message encoded in the utilized strategy and the possible cause for its eventual failure. (i.e. the discrepancy between the threat of abandonment and need for security, placating in one situation and disapproval on another occasion.)

C) The therapist emphasizes the necessity for clarification of one's own feelings, intention and unambiguous communication.

D) The homework assigned is list of what changes in attitude, understanding, and behavior have taken place as the result of the treatment sessions and what are the major issues that remain unresolved.

SESSION 12

A) The therapist receives and discusses the homework, emphasizing the function of counseling and therapy as pointing the direction rather than traveling to the destination.

B) The therapist summarizes the key concepts of the model and the individual variations as well as the manner that each individual can work towards eliminating or reducing harm to herself/himself and others in the family.

**Twelve sessions is the minimum number necessary to cover the key concepts. Depending on the rate of progress each concept may require 2-3 sessions.

APPENDIX I.

PSYCHO/SOCIAL SCREENING CHECKLIST

(Private or institutional/to be administered in a medical setting/to be part of the medical record)

Please complete the following checklist, placing a check next to the category which most accurately describes what has happened to you IN THE LAST SIX MONTHS.

	Never/rarely	Frequently	Almost all the time
1. How often do you wake up feeling sad?			
2. How often are you kept up at night with frightening or sad thoughts or feelings?			
3. Have you ever thought that life is not worth living?			
4. Have you ever thought of ending your life?			
5. Do you ever feel frightened without any specific cause?			
6. Does fear ever keep you from doing things you want to do?			
7. How much do you drink (beer, wine, hard liquor)?			
8. How often do you take over the counter sleeping medication?			
9. Have you ever taken over the counter diet medication			
10. How often do you take over the counter pain medication?			
11. Are you ever afraid of your partner?			
12. Do you ever worry that your arguments may turn violent?			
13. Does your partner demand that you should not keep relationships with friends and family?			
14. Are you jealous of your partner's relationships with his/her friends and family?			
15. Does your partner act extremely jealous or possessive of you?			
16. Does your partner demand that you stop participating in outside activities because of your relationship?			

ANSWER KEY:

Questions in this screening tool have been devised to alert the practitioner to the possible contribution of psychological factors in the presenting clinical picture.

The questions are clustered as to their most likely significance for pointing to specific areas of psychiatric problems. If 50% or more of the questions (16) are checked as "frequently" or "almost all the time", an in-depth interview with a mental health practitioner is indicated in order to clarify the extent of the problem.

Cluster A: questions # 1, 2, 3, 4, 8, 10, 23, 24, 25, 26
If answered "frequently" practitioner rules out depression;
If answered "almost all the time", refer to mental health counselor
If answered "yes" (questions # 24-26), refer to mental health counselor

Cluster B: questions # 5, 6, 8, 12, 23
If answered "frequently", practitioner rules out Generalized Anxiety Disorder
If answered "almost all the time", refer to mental health counselor

Cluster C: questions # 11, 12, 13, 14, 15, 16, 17, 18, 19, 20
If answered "frequently", practitioner rules out Disorder of Intimacy
If answered "almost all the time", refer to mental health counselor

Cluster D: questions # 27, 28, 29, 30, 31, 32, 33
If answered "frequently", practitioner rules out Post Traumatic Stress Disorder
If answered "almost all the time", refer to mental health counselor
If answered "yes", (28,31,32,33) refer to mental health counselor

CHOICES WOMEN'S MEDICAL CENTER

PSYCHO/SOCIAL SCREENING TEST

Please complete the following checklist, placing a check next to the category which most accurately describes what has happened to you **IN THE LAST SIX MONTHS**.

	Never/Rarely	Frequently	Almost all the time
1. How often do you wake up feeling sad?			
2. How often are you kept up at night with frightening or sad thoughts or feelings?			
3. Have you ever thought that life is not worth living?			
4. Have you ever thought of ending your life?			
5. Do you ever feel frightened without any specific cause?			
6. Does fear ever keep you from doing things you want to do?			
7. How much do you drink (beer, wine, hard liquor)?			
8. How often do you take over the counter sleeping medication?			
9. Have you ever taken over the counter diet medication?			
10. How often do you take over the counter pain medication?			
11. Are you afraid of your partner?			
12. Do you ever worry that your arguments may turn violent?			
13. Does your partner demand that you should not keep relationships with friends and family?			
14. Are you jealous of your partner's relationships with his/her friends and family?			
15. Does your partner act extremely jealous or possessive of you?			
16. Does your partner demand that you stop participating in outside activities because of your relationship?			
17. Has your partner embarrassed or humiliated you in public?			
18. Do you worry about making your partner angry?			
19. Do you know what makes your partner angry?			
20. Do you ever feel that your partner controls more than you would like?			
21. How often has your partner bullied you, verbally abused you or physically abused you?			
22. How often have you bullied, verbally abused or physically abused someone?			
23. How often are you afraid of hurting someone?			

CHOICES WOMEN'S MEDICAL CENTER

PSYCHO/SOCIAL SCREENING TEST

24. Do you suffer from chronic genital (reproductive), urinary tract, gastric or structural problems? Yes ____ No ____

25. Do you suffer from unexplained ailments, i.e.; pain, stomach aches, dizziness? Yes ____ No ____

26. Do you have difficulty with your appetite (not good or too much)? Yes ____ No ____

27. Have you recently suffered some form of stress or trauma? If so, what? _____

_____

_____

28. Have you pressured someone to have sex or have been pressured to have sex? Explain. _____

_____

_____

29. How often do you experience pain during intercourse? _____

30. How often is sex unsatisfying for you? _____

31. Have you ever been raped or sexually molested? When _____ By Whom? _____

32. Have you ever been physically assaulted? When _____ By Whom? _____

33. If you have been physically or sexually assaulted have you ever:

a) Had flashbacks or nightmares about it? Yes ____ No ____

b) Been counseled regarding it? Yes ____ No ____

c) Know it to cause problems with medical examinations? Yes ____ No ____

d) Know it to cause problems in relationships with others? Yes ____ No ____