The Mental Health Impact of Domestic Violence

Grantmakers in Health
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Overview

- Introduction
- Things to keep in mind
- Why address these issues?
- The need for cross-sector collaboration
- Trauma theory as a bridge
- Building collaborative models
- Implications for policy and practice

Domestic Violence & Mental Health Things to Keep In Mind

- Defining domestic violence
- Role of the DV service sector
- A natural question
- Risks survivors face

Defining Domestic Violence

a pattern of behavior used to establish power and control over another person with whom an intimate relationship is or has been shared through fear and intimidation, often including the threat or use of violence. Battering happens when one person believes that they are entitled to control another.

-National Coalition Against Domestic Violence

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-National Coalition Against Domestic Violence

The DV Service Sector

Local Programs Served 65,321 women and children in one day in 2009

- Individual Advocacy
- Emergency Shelter
- Children's Advocacy
- Legal Advocacy

National and local hotlines answered 23,045 calls.

2009 DV Counts, NNEDV

Why doesn't she leave?

This natural question suggests that ending the crime of domestic violence is under the control of the victim/survivor.

The natural question is not the most helpful one.

Greatest risk of injury or death is around the time of leaving an abusive partner (BJS 2000)

Leaving an abusive partner is a decision making process of weighing batterer-generated risks against life-generated risks. (Davies & Lyon, 1998)

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Why Address These Issues?

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DV Increases Women's Risk for Depression, PTSD & Suicide

Diagnosis	Prevalence*
Depression	50.0%
PTSD	61.0%
Suicidality	20.3% (53.6%)**

*Weighted mean prevalence across studies. Rates differ by setting.

- In shelters, Depression = 63.8%, PTSD = 66.9%, Suicidality = 29.6%.
- For court-involved women, Depression = 73.7%
- In mental health settings, Suicidality = 53.6%
- DV also increases risk for post-partum depression

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- J. Golding et al 2000

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Yet. Context is Important, Too

- **Complicated by length and type of exposure**
  - Traumatic Context: Custody, visitation, mediation
- **Cessation of violence & social support reduce depression & PTSD but for some women they can persist**
- **Treatment and parenting support are effective**

Young-Bruehl **Kaysen et. al.; ***Krause et. al. 2006, Follingstad 1991, Campbell 1999, Sullivan and Rumptz 1994, Allard 1997, Thompson et al 2006, Bonomi et. al. 2006

DV and Suicide

- DV increases women's risk for suicide
- Do we ask routinely?

- **Inpatient MH settings**
  - **>90%** women hospitalized post-suicide attempt reported current severe DV
- **Community Settings**
  - **23%** of DV survivors reported past suicide attempts vs. 3% with no history of DV
  - **36.8%** of DV survivors seriously considered suicide

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Coker 2002, Pico-Alfonso 2006, Seedat 2005, Heru 2006

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Abuse and Violence

Play a Significant Role in the Development and Exacerbation of Mental Health & Substance Use Disorders

Adverse Childhood Experiences Study

N=9,508 &17,337 Adults in HMO

Physical, Sexual, Psychological abuse, Witness violence toward mother, Household members with substance abuse, Suicide Attempts or Incarceration

- **50% at least one**
- **25% reported 2 or more**
  - Women are more than 3.5x as likely to have experienced 5 or more ACEs
- **Dose response between # of experiences &:**
  - Alcoholism, drug abuse, Depression, Smoking,
  - Poor health, 50 or more sexual partners, obesity and physical inactivity
  - CHD, CA, liver disease, skeletal fractures, COPD
  - Psychiatric hospitalization, suicide attempts, hallucinations
  - Any ACE increased suicide risk by 2-5X

Felitti et al 1998, Dube et al 2001, Weigh et al. 2010

Traumatic Experiences: Prevalence in the US: National Co-Morbidity Study

N=5,877 ages 15 to 54

- Lifetime trauma exposure:
  - >60% men; >50% women
- PTSD in general population
  - Rates are twice as high among women
  - 5% men, 10.4% women
- PTSD if exposed to trauma
  - 8% men and 20% women; 30% chronic
  - Different types of exposure by gender
  - PTSD & MDD in girls abused < 13, PTSD in girls abused > 13*

Kessler RC et. al. *Archives of General Psychiatry.* 1995;52(12):1048-1060,
*Weigh et. Al. 2010

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Childhood Trauma & DV Increase Women's Risk for Substance Abuse

- **Higher rates** among women who have been victimized
  - Women with 4 or more ACEs had a 7x increase in ETOH dependence
  - For Native women, sexual abuse & boarding school attendance increased the odds of alcohol dependence.
- **Self-medication** common; may be symptom specific
- May be **coerced into using** or dealing
- May be **prevented from abstaining**
- **Increases risk for coercion**

At the same time…..

Women Seen in Mental Health Settings Are at Greater Risk for Abuse

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High Rates of Abuse & Violence Among Women Receiving MH Services

Type of Abuse	OP Prevalence	MI
Adult physical	42%-64%	87%
Adult sexual	21%-41%	76%
Child physical	35%-59%	87%
Child sexual	42%-45%	65%

Women living with chronic mental illness experience higher rates of abuse Women abused in childhood experience higher rates of psychiatric symptoms, homelessness and sexual assault as adults Women in inpatient settings experience high rates of DV

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Jacobson 89, Lipschitz et al 96, Goodman et al 95, Friedman 2007

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DV and MI: Inpatient Studies

- **Lifetime Exposure**
  - 44% women Adult PA; of those 59% IPV
  - 62% women experienced IPV
- **Current Exposure**
  - 64% adult PA; of those 56% living with perpetrator
- **Those with ongoing relationships (M,F)**
  - 62.8% partner, 29% past year
  - 45.8% PA by family member

Bryer, et al. 1987. Carmen et al. 1984, Jacobson & Richardson, 1987
Cascardi et. Al. 1996.

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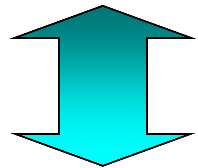
Why is this? Risk vs. Vulnerability

- **Batterers use MH issues to control their partners**



- **Stigma, poverty, discrimination & institutionalization compound these risks**

- Control of meds
- Coerced overdose
- Control of treatment
- Undermining sanity, credibility & parenting
- "She was out of control"

WHY DOES THIS WORK?

- Reports of abuse attributed to delusions
- Symptoms of trauma misdiagnosed as MI
- Assumptions that having a MI precludes good parenting
- Internalized stigma

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Survivors Experience Multiple Types of Trauma

- **Childhood victimization increases risk for abuse as adolescent or adult**
- **Coping strategies may increase risk:**
  - Substance use & Dissociative states: ability to attend danger signals
- **Not learn have right to protect oneself from harm.**
- **Survivors also experience social, political, cultural, historical, & immigration-related trauma**

- Fabri: Triple Trauma Paradigm; Root: Insidious trauma, Braveheart: Cultural and Historical Trauma

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Trauma can affect our responses as providers

- Without a DV/trauma framework, services can be endangering & retraumatizing
- Understanding DV & trauma can lead to more effective responses
- “Trauma-Informed” does not mean “Trauma-Defined”

What the Numbers Tell Us…

- DV and other trauma are pervasive
- It can have long-lasting health and mental health effects
- Survivors often experience multiple forms of victimization
- Women who have a psychiatric disability are at greater risk
- Ongoing DV requires attending to abuser behavior as well as impact on survivor
- There are many opportunities to counter these effects

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DV, Trauma & MH

- This does not mean that most domestic violence survivors are in need of "mental health treatment"
- We are all affected by experiences of terror, violation and control
- Individual healing ⟺ Social transformation

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The need for Cross-Sector Collaboration

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Cross-Sector Collaboration is critical to…

- Safety, custody, credibility,
- Access to resources, gender-specific services
- Recovery
- **Prevention**

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Where does that leave survivors? The Need for Cross-sector Collaboration

- **DV programs**
  - Seeing more women with complex needs
  - Concerns re: MH response to survivors
  - Need for collaboration to address MH
- **MH & SA systems**
  - Recognize pervasiveness of trauma
  - Concerns re: DV response to MH
  - Need for collaboration to address DV

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Issues for Collaboration:
Concerns of DV Programs & Survivors

Philosophical Barriers

- Survival strategies seen as disorders
- Meds not tied to other services
- Involving batterers in treatment
- Stigma
- Dangers of couples counseling
- Importance of advocacy unrecognized

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Bridging the Gap
Addressing Philosophical Barriers

Advocacy Model	Clinical Model
Power & control	Individual or System Pathology
Safety & empowerment	Control of Symptoms
Advocacy, Support, Access to resources	Treatment, Medication

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Issues for Collaboration:
Concerns of DV Programs & Survivors

Practical Barriers

- **Availability & Accessibility**
  - Linguistic and cultural appropriateness
  - Priorities, time and cost
  - Transportation and childcare
  - Abuser control of insurance
- **Service quality**
  - Choice of provider?
  - Knowledge about DV?
  - Trauma-informed, Trauma-specific?
  - Gender-specific services?

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Issues for Collaboration: Survivors Recommend

Women in DV Shelters

- **Provide long-term counseling at DV programs**
- **Train mental health providers to:**
  - ✓ Understand dynamics of DV
  - ✓ Become aware of community resources
  - ✓ Not blame victims
  - ✓ Be wary of abuser control of treatment
  - ✓ Not overemphasize the role of medication

Women in MH Settings

- ✓ Want information
- ✓ Want access to resources
- ✓ Want support
- ✓ Want gender-specific services
- ✓ Want DV & trauma-specific services

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Challenges for Collaboration

Common Goals

- Health, Safety, Freedom, Connection

Different Focus

- Healing the consequences of abuse
- Achieving sobriety
- Mobilizing resources to end the abuse

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Trauma Theory as a Bridge

- Normalizes human responses to trauma
- Shifts our conceptualization of symptoms
  - **Injury model**
  - **Symptoms as survival strategies**
- Integrates multiple domains
  - **Developmental, biological, emotional, cognitive, spiritual, relational**
- Multidimensional treatment models
- Impact on providers & organizations

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Emergence of Trauma Theory:
Reframing MH Symptoms from a Trauma Perspective

- **1980's PTSD**
  - Disabling effects of recent abuse
  - Vietnam veterans; Sexual Assault and DV movements
- **1990's Complex Trauma**
  - Developmental effects of chronic abuse
  - CSA/MH system survivors movement
  - Child trauma field
  - ACE study & CIDI studies
  - PTSD + Co-morbidities vs. Complex Trauma
- **2000's Genetic & Neuroscience Research**
  - Psychophysiological correlates

Herman 1994, 2009, van Der Kolk and Courtois 2005, Courtois 2009, Ford 2009

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What Do We Mean by “Trauma”?

Trauma is the unique individual experience of an event or enduring condition, in which:

- The individual experiences a threat to life or to their psychic or bodily integrity
- The individual’s coping capacity and/or ability to integrate his or her emotional experience is overwhelmed
- Cultural and historical trauma can impact individuals and communities across generations

Mental Health in the Context of DV and Other Trauma: Complex Picture

- **Direct effects of perpetrator behavior**
- **Trauma-related symptoms**
  - Mental health effects of DV + other types of trauma
- **Survival strategies**
  - Hypervigilance, passivity/compliance
- **Exacerbation of pre-existing MH conditions**
- **Active undermining of parenting**
- **Role of cultural barriers & supports**
- **Role of stigma and provider, institutional, societal responses**

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PTSD vs. Complex Trauma Paradigm

PTSD

- Discrete event; predictable impact; related domains; definable time course
- **Symptoms**

Complex Trauma

- Repeated trauma, often in childhood
- Core experience, organizes development
- Complex pattern of actions and reactions
- Continuing impact; multiple domains
- Borderline reframe
- **Meaning**

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Maxine Harris and Roger Fallot, 2001

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Where does that leave us?
Gaps & Unmet Needs

- Culture, Community, Spirituality
- DV in Context of Lifetime Trauma
- DV in Context Of MI
- Parenting Children who Experience DV
- DV, Trauma & the Legal System
- DV, Trauma & Public Policy
- DV, Trauma & Substance Abuse

Model Programs & Collaborations

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DVMHPI Local and State Projects

- Intensive Trauma Training and Implementation Project
- Chicago Department of Public Health/Mayor's Office on DV
- OVW Domestic Violence & Psychiatric Disabilities Project
- Child Trauma Capacity-Building Project*

*Child Trauma Research Program UCSF, DVMHPI, Irving Harris Foundation

Child Trauma Capacity-Building Project Curriculum for DV Advocates

- Training for advocates and their supervisors
- Both shelter and non-shelter programs
- Philosophy: use the advocacy relationship to support the parent-child relationship
- Philosophy: parent-child relationship is the source of the child's feeling of protection after trauma and the child's recovery
- Extended training model: didactic training and case-based follow-up consultation x 18 months
- Case/vignette based learning

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National Center Multi-State Initiative

- **Center State Partners**
  - WV and PA
  - KS, DE and Transformation Detroit
  - IL, FL, WA, AK
- **Open Doors Partners**
  - ID, NH, AL
- **Three year project**
  - **State Coalitions**: Multiple approaches; pooled knowledge
  - **Center:** Consultation (needs assessment, planning and implementation, building collaboration), site visits, training, joint meeting, evaluation, model practices report

Implications for Practice: Culture-, Trauma-, and DV-Informed Services

- Ongoing training and consultation
  - Orientation, basic, advanced
- Ongoing reflective supervision
  - Requires administrative support
- Agency culture
  - Bootstraps vs. nurturing, survival under various sorts of siege
  - Staff turnover: Salaries, burnout, HR
  - Reflective leadership

Developing Collaboration at State and Local Levels

- **Practical Issues**
  - Identifying potential partners and allies
  - Developing common goals
  - Developing strategies when resources are limited
- **System Issues**
  - Information sharing and confidentiality
  - How survivors are treated in other systems
  - Support for collaboration building
    - Cross-training, cross-consultation, cross-referral
    - Integrated models and approaches
  - Funding silos; diminishing resources

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Overall System Change

- **MH & SA systems:**
  - Gender-responsive; DV, Culture & Trauma-informed; DV, Culture & Trauma-competent
- **DV advocacy services:**
  - Fully accessible and welcoming
  - Comprehensive onsite services; Comprehensive array of services through community partnerships
- **Other community resources**
  - Disability rights and Peer Support programs
  - Primary Care providers; Legal & CPS systems
- **Prevention**

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NATIONAL Center on Domestic Violence, Trauma & Mental Health

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NATIONAL Center on Domestic Violence, Trauma & Mental Health

The Center offers:

- **Information** about current practice, model approaches, and successful collaborations;
- **Tools** to improve policy and practice and enhance collaboration;
- **Training** to assist with designing appropriate, accessible, and culturally-relevant services;
- **Consultation** for organizations and systems to address the needs of survivors of domestic violence in local and state jurisdictions, and at the national level;
- **Facilitation of critical thinking** about the complex intersections of domestic violence, trauma, and mental health.

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