

INFORMATION BRIEFING – NO. 5

Impact of domestic abuse on women's mental health

Introduction

"I don't call it mental health, I call it 'symptoms of abuse', because to me that's what it is" (Gail, survivor of domestic abuse in Humphreys 2003).

Despite huge efforts and achievements in tackling domestic abuse across Scotland, it remains an endemic and largely hidden problem which jeopardises women's mental health. Research shows that rates of depression are much higher among women experiencing domestic abuse than the general public (Helfrich et al 2008). Domestic abuse is also likely to be the most common single background factor for female patients in mental health settings (Sutherland et al 1998). The response that women encounter through mental health services is often one which individualises the symptoms. However, in order to fully support women's mental health, it is vital that the symptoms are viewed within the wider context of abuse experiences.

This information sheet outlines the impact of domestic abuse on women's mental health, with consideration also of the responses from service providers. 85
For information specific to children and young people, see information briefing: *'The impact of domestic abuse on children and young people.'*

The impact of domestic abuse on mental health

There has been much research into domestic abuse and a range of effects on women's mental health have been identified. Research has commonly focused on depression, self harm, attempted suicide and post traumatic stress disorder (PTSD).

Depression – depression has consistently been highlighted as a common consequence of domestic abuse. A comparative study in the US found that 51.4% of women living in refuges had major depression, compared to 2.4% of the general population (Helfrich et al 2008). Depression can have profound impact on women's day to day lives. It affects her employment, education, ability to pursue goals and cope in social environments (Helfrich et al 2008). Women often experience feelings of powerlessness, anxiety and low self-esteem. There is also a strong relationship between symptoms of depression and chronic health problems. While injuries from physical violence have a direct impact on women's physical health, the injuries alone do not account for the complex array of physical health problems women experience. It is likely that stress plays a major role in explaining the relationship between domestic abuse and physical and mental health issues (Sutherland et al 2002).

Self harm – Research has shown strong links between abuse, self harm and suicide attempts (Holmshaw and Hillier 2000). Self harm is a leading cause of A&E attendance and hospital admission. A study in Cambridge indicated that domestic

abuse is significantly associated with increased risk of self harm, with around 25% of victims of domestic abuse presenting at A&E departments having self-harmed (Boyle et al 2006). Victims of domestic abuse also show greater attendance at emergency medicine departments than the general population (Boyle et al 2006).

Suicide – discussions on suicide tend to be in relation to men, as they are more likely to die from suicide than women. Although less likely to die from a suicide than men, significant numbers of women who experience domestic abuse do attempt to end their lives. It is important that the context in which they occur is not lost, and research has shown specific links between suicide attempts and physical and sexual abuse; women who have experienced physical or sexual abuse are more likely to attempt or at least think seriously about committing suicide than women who haven't experienced domestic abuse (Holmshaw and Hillier 2000).

Post Traumatic Stress Disorder (PTSD) – PTSD is an anxiety disorder associated with serious traumatic event. Someone with PTSD may experience a range of symptoms such as flashbacks or nightmares that cause the person to relive the traumatic event, anxiety, emotional numbing, insomnia, hyper-vigilance, and avoidance of people or places that might trigger flashbacks. Researchers consider it the most commonly diagnosed mental disorder for women who have experienced domestic abuse; studies estimate between 31% and 84% of women with a history of domestic abuse meet the diagnostic criteria for PTSD (Hughes and Jones, 2000), which is much higher than the 1.2% to 12% prevalence rates found among community samples (Golding, 1999).

The extent, severity, type of abuse, as well as history of previous trauma and a partner's controlling behaviour are associated with the intensity of PTSD. More severe forms of violent physical abuse have been associated with greater traumatic impact. However, recent studies also indicate that psychological abuse is a more consistent predictor of PTSD (Mechanic, Weaver and Resick, 2008). Research also indicates that women experiencing domestic abuse who develop PTSD may use drugs or alcohol to calm or cope with the intrusion, avoidance and hyper arousal symptoms which are associated with PTSD (Campbell 2002).

Key findings:

- 70-85% of abused women experience at least mild depression and 30-55% severe depression (Sutherland et al 2002).
- Attempted suicide is most common amongst women and has been linked to experiences of physical and sexual abuse (Holmshaw and Hillier 2000).
- Women who experience domestic abuse may experience panic attacks, high anxiety, hyper vigilance and have no concept of a future (Humphreys 2003).

Making the connection between domestic abuse and mental health

In order to understand the dynamics and impact of domestic abuse on women's mental health, it is useful to draw on Evan Stark's theoretical model of coercive control. According to Stark (2007),

"Coercive control entails a malevolent course of conduct that subordinates women to an alien will by violating their physical integrity (domestic violence), denying them respect and autonomy (intimidation), depriving them of social connectedness (isolation), and appropriating or denying them access to the resources required for personhood and citizenship (control)."

It is the combination of tactics employed by a perpetrator that effectively entrap women and compromise their mental health. Stark likens women experiencing coercive control to hostage victims, with the focus not on incidents of physical violence, but on the 'liberty crime' which is made up of a web of tactics of which physical violence is just one tool of control.

Campbell et al (2005) have taken an ecological approach to understanding the relationship between domestic abuse and mental health, focusing on the abusive relationship as well as the woman's social environment. Their research highlights key elements which mediate the effect of a perpetrator's abuse on a woman's mental health, which include imbalances in power and control, the violence itself and the wider social environment and support (Campbell et al 1995).

Service responses

Responding appropriately to women experiencing domestic abuse requires a holistic understanding of their experiences and support needs. Although research indicates that domestic abuse is likely to be the most common single background factor for women in mental health settings, the response from mental health services has been criticised as inadequate and often inappropriate (Humphreys and Thiara 2003, Humphreys 2003, Plichta 2007).

Women's experiences of the mental health sector have been reported as neutral to negative (Humphreys and Thiara, 2003). The direct connection between women's symptoms and the domestic abuse they experience is often lost in mental health services, and it is common for victims to be labelled with a 'personality disorder'. This has the effect of individualising and medicalising the social problem of domestic abuse. Furthermore, it also serves as a confirmation of the perpetrator's verbal abuse 'you're crazy' and deepens a woman's loss of self esteem and empowerment. The perpetrator's responsibility for the abuse is often invisible within mental health services as the focus turns to the treatment of the woman's 'mental illness' (Humphreys 2003).

Good practice within mental health settings has been identified as that which names the abuse. One of the perpetrator's tactics of abuse is to shift responsibility onto the woman. By remaining silent about abuse mental health services collude with it, but if they name it, they help the woman in the first stage of recovery. Services which demonstrate good practice respond with sensitivity, an attitude of

belief and provide non-judgemental support (Humphreys 2003). Many women mention support services outside of the mental health sector to be particularly helpful, where the focus tends to be on areas such as advocacy, counselling and group work (Humphreys and Thiara 2003).

Key findings:

- After a woman has presented herself several times to A&E she is likely to be labelled as suffering depression and 'personality disorder'. The control exerted by the abuser, particularly evident in her continuing to live with him, becomes seen as a symptom and indicator of the woman's mental health problems rather than the source (Humphreys and Thiara 2003).
- Women experiencing domestic abuse tend to have worse communication with their healthcare providers. Research suggests they would like to be actively asked whether they are experiencing domestic abuse (Plichta 2007).
- Research indicates that the majority of women find medication less useful and possibly dangerous due to the effects it has on their ability to respond and react to the abuse (Humphreys 2003).

In summary, domestic abuse has profound consequences on women's mental health. Women experiencing domestic abuse are more likely to suffer from depression and post traumatic stress disorder and are also more likely to self harm or attempt suicide. While these diagnostic labels are useful in recognising the pattern of effects on mental health, it is important that the direct connection between women's symptoms and the domestic abuse they experience is not lost. Indeed, mental health services have been criticised for focusing on treating the mental illness and losing sight of the perpetrator and the abuse which lies at the root of the problem. It is only when the trauma associated with domestic abuse is fully recognised, the abuse named, and women are responded to within a non-judgemental environment of belief, that the mental wellbeing of women experiencing domestic abuse will be addressed effectively.

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