# Domestic/sexual abuse and its association with mental health problems

Dr KYLEE TREVILLION

Senior Lecturer at the Institute of Psychiatry, Psychology & Neuroscience, King's College London, UK

# Definitions and social determinants

# Definitions

"***a pattern*** *of behaviour in any relationship that is used to gain or maintain power and control over an* ***intimate partner***" (United Nations)

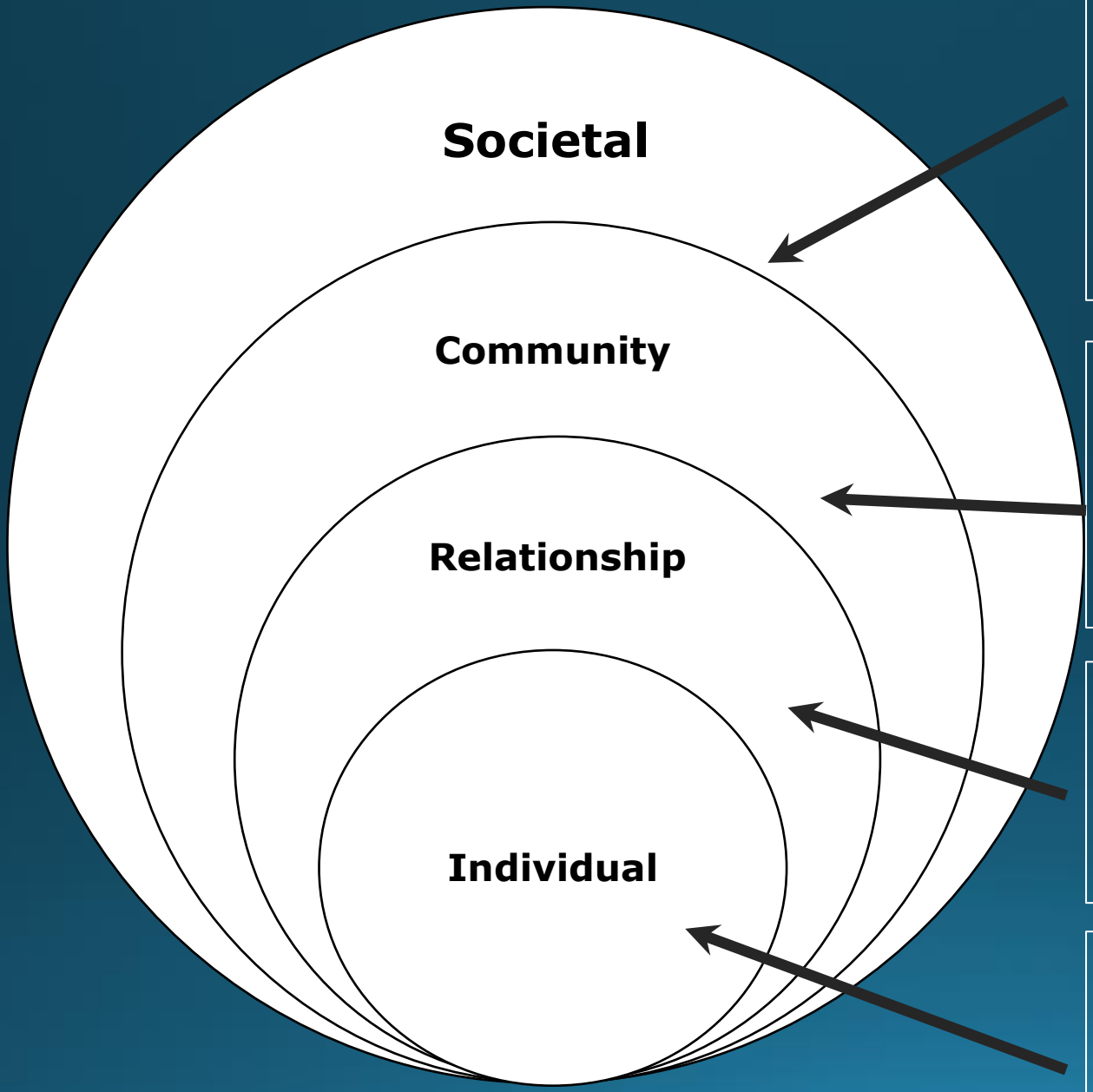
UK Home Office - "**Any incident or pattern of incidents** of controlling, coercive, threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between those aged 16 years or over who are, or have been, **intimate partners or family members**, regardless of gender or sexuality"

# Sexual abuse

Sexual assault is an act of physical, psychological and emotional violation, in the form of a sexual act, which is inflicted on someone without consent. It can involve forcing or manipulating someone to witness or participate in a sexual act or touching someone sexually without their consent

https://rapecrisis.org.uk/get-informed/about-sexual-violence/what-is-sexual-violence/

# Ecological model




Discriminatory laws on gender
Gender discrimination in institutions
Economic inequalities
Lack of enforcement of laws on violence
Cultural norms of violence

High crime/unemployment
High residential mobility
Harmful gender norms
Access to drugs/weapons
Poverty
Gender stereotypes

Gender inequality
Poor parenting practices
Violent parental conflict
Low socioeconomic status
Marital conflict

Victim of child abuse
Mental health/substance use problems
Violence seen as normal

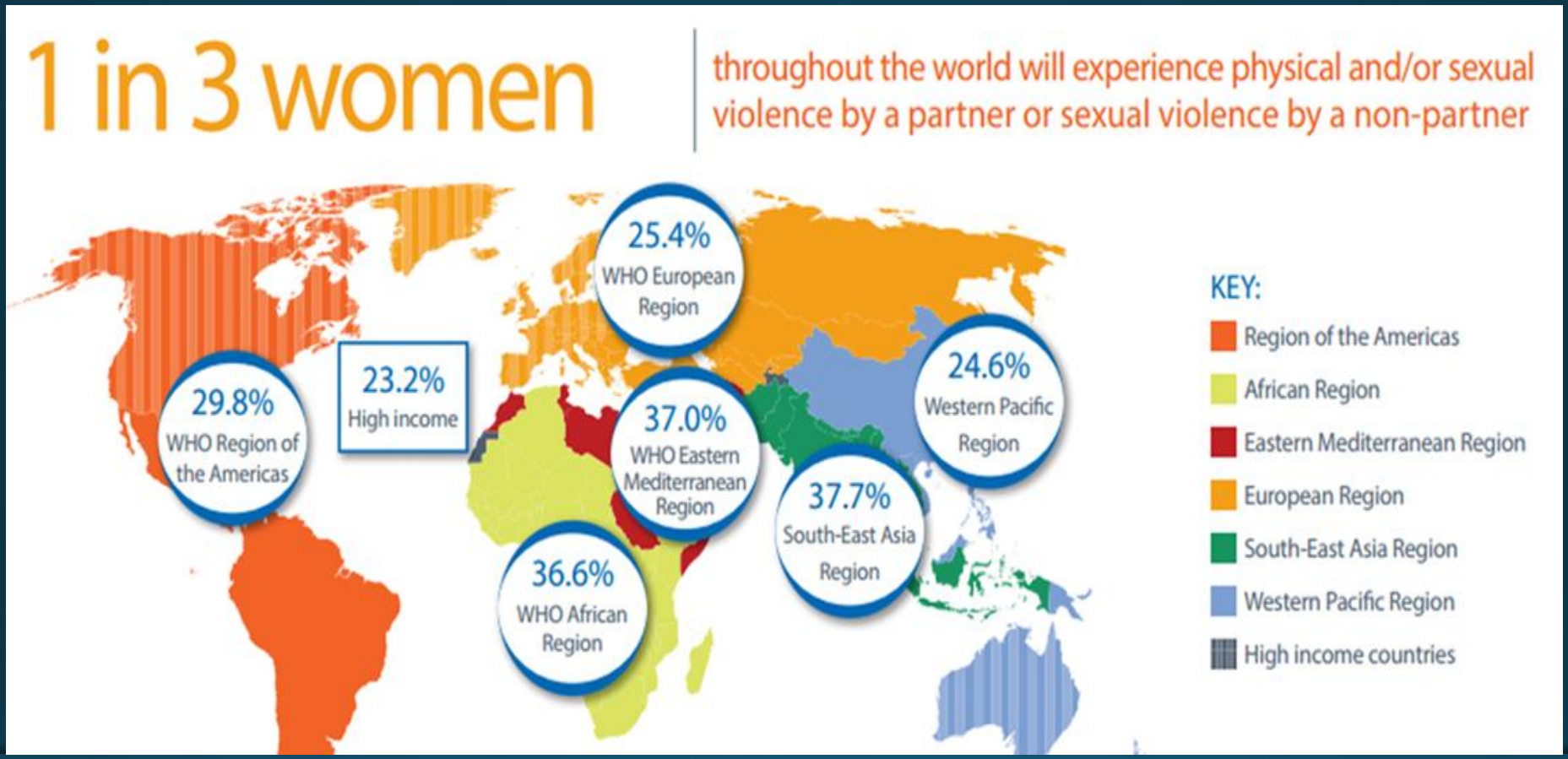
(Heise 1998; WHO 2018; Abramsky et al 2011)

# Prevalence and impacts

# Gender and interpersonal violence

- Women much more likely than men to experience repeated, coercive, severe forms of DVA
- Women much more likely to experience sexual assault
- Women most likely to be killed by someone they know
- 1 in 5 homicides globally perpetrated by an intimate partner/family member – women/girls most often victims
- Women 6 times more likely to be killed by intimate partner than men (39% vs 6%)

(United Nations Office on Drugs and Crime 2018; Stockl 2013)




- Globally, 30% of women report physical and/or sexual partner violence
- Across Europe, 25% of women report physical and/or sexual partner violence

***(World Health Organisation 2014)***

# Covid-19 and DVA rates

Increase in prevalence of DVA during pandemic emergencies, including COVID-19

Covid-19 DVA police reports in London by current partners/family members increased but those by ex-partners decreased

Possible under-reporting of DVA if limited opportunity to escape abuse (higher reports from third-parties seen)

Possible explanations for these trends:

- Economic insecurity/stress
- Quarantines/ lockdown measures exacerbate perpetrators power over survivors (through social isolation, inability to escape abuse)
- Reduction in access to support services
- Switch to online support may not be appropriate

**(Peterman et al 2020; Pentaraki and Speake 2020; Ivandic et al 2020; Leslie and Wilson 2020)**

# Gender and sexual abuse

Around 18% girls and 8% boys report a history of childhood sexual abuse

Youth surveys indicate 27% of females and 5% of males have experienced sexual assault

In adulthood, women report much higher rates of sexual assault than men [e.g. 22% of women vs. 4% men; Elliott et al 2004]

Risk factors for adult sexual assault include:

- Younger age
- Being female
- Experience of sexual abuse in childhood

LGBT women more likely than LGBT men to report child, adult and intimate partner sexual assault:

- Median estimate of lifetime sexual abuse was 43% for women and 30% for men

***(Rothman et al 2011; Stoltenberg et al 2011; Elliott et al 2014; Finklehor et al 2014)***

# Re-victimisation

Approx. half of people who experienced child sexual abuse experience further re-victimisation

Factors predicting sexual assault re-victimisation:

- Female
- Abuse prior to age 12
- PTSD, anxiety disorders, personality disorders

Factors predicting non –sexual re-victimisation:

- Male
- Anxiety disorders, substance use issues, personality disorders

**(Walker et al 2019; Papalia et al 2020)**

# Impacts on Health

**Injuries following an assault**

e.g. fractures, broken bones, facial injuries, scars

**Chronic illness after living with abuse**

e.g. headaches, gastrointestinal disorders, chronic pain

**Psychological or psychosocial problems**

e.g. attempted suicide, depression, anxiety, substance abuse

**Gynaecological problems**

e.g. sexually transmitted infections, chronic pelvic pain, recurrent urinary tract infections

# What is the link between violence victimisation and mental health problems?

# Reviews of domestic abuse and mental disorders

Past year DA prevalence

Depression: 35.5% (IQR 16%-40%)

Anxiety: 28.4% (IQR 26%-42%)

Lifetime DA prevalence

PTSD: 61% (IQR 41%-80%)

Odds Ratio

Depression: 3.31 (2.35-4.68)

Anxiety: 2.29 (1.31-4.02)

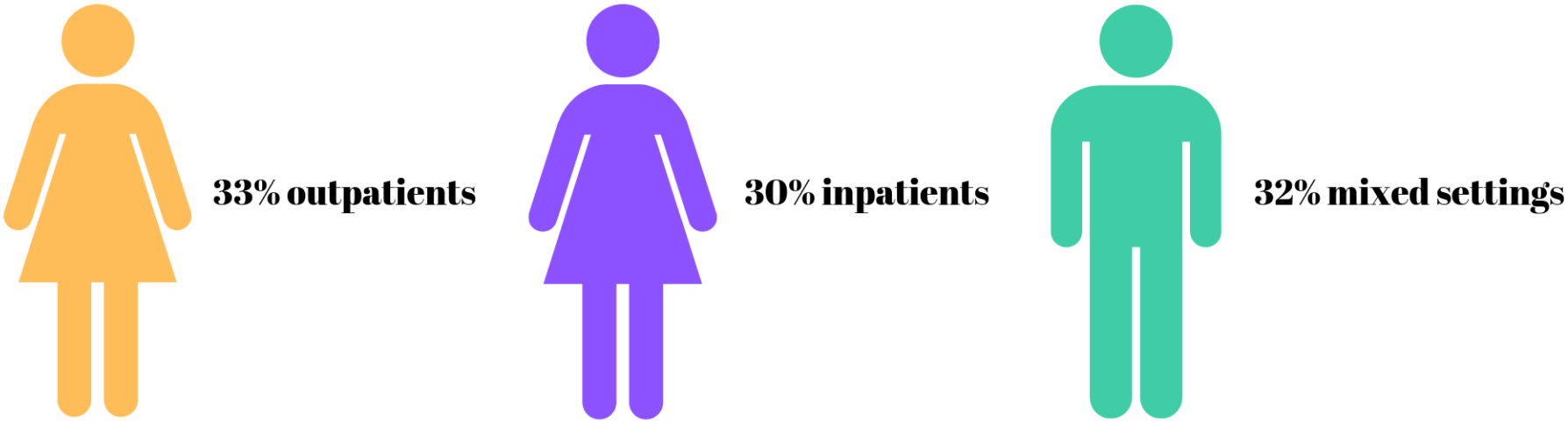
PTSD: 7.34 (4.50-11.98)

- Eating disorders associated with higher prevalence of lifetime DA (8 papers, n=6,775 women)

(Trevillion et al 2012; Oram et al 2013)

# Reviews of domestic abuse and mental disorders

## Prevalence of DVA among mental health service users




(Oram et al 2012)

# Mental Health and Justice Survey

Cross-sectional survey:

- Random sample of people in two London mental health trusts
- Interviewed using modified Crime Survey for England and Wales (CSEW)
- Compared group with London residents who answered CSEW

Patients:

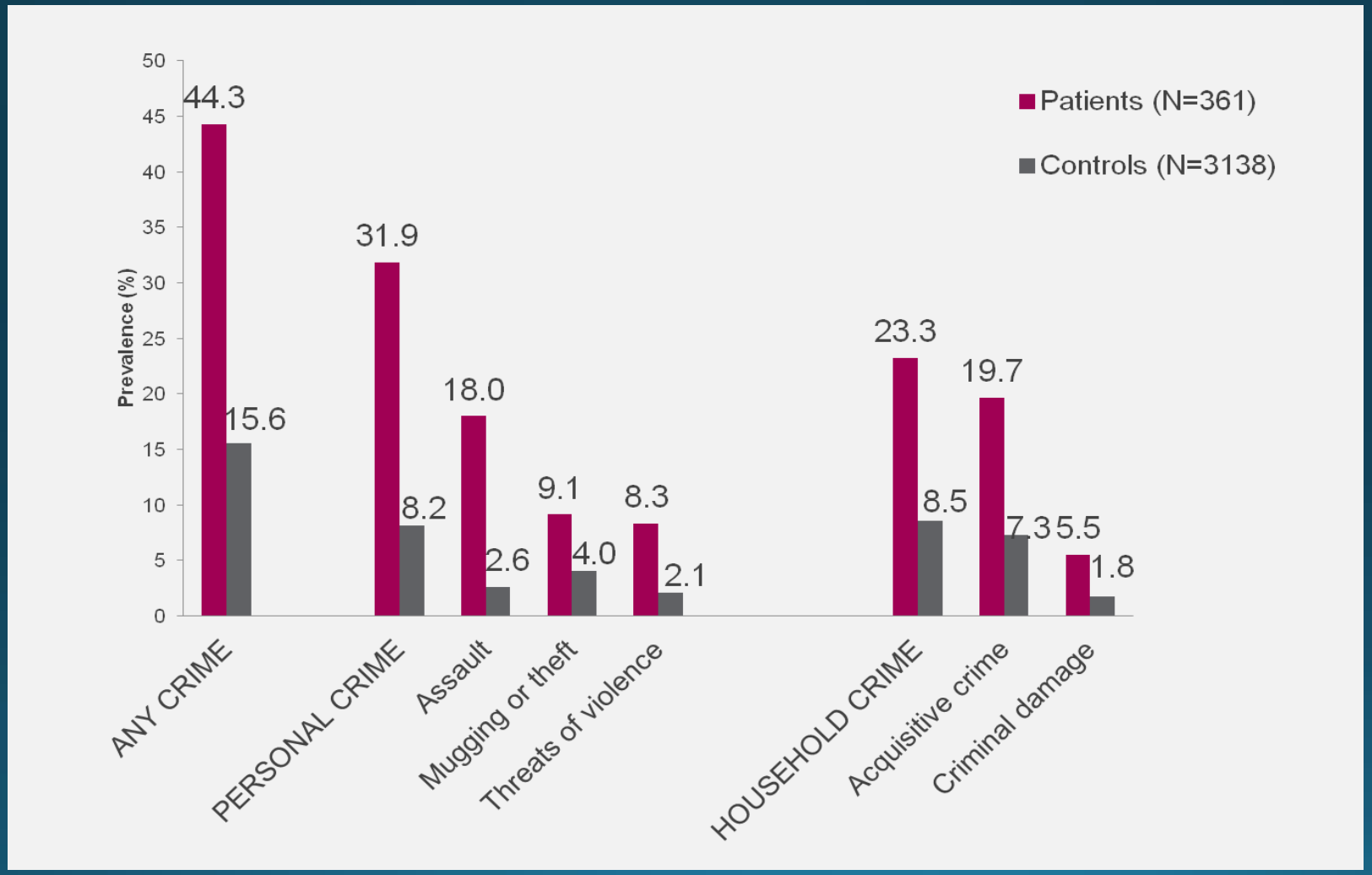
Age 18-65 / CPA care >=1 year / case note diagnosis of schizophrenia / related disorders (ICD10 F20-F29) or mood disorders (F30-F39) Exclusion: language, capacity, primary substance misuse

Comparison group:

2011/2012 ONS-CSEW / Aged 18-65 / London resident / Exclusion: MI disability

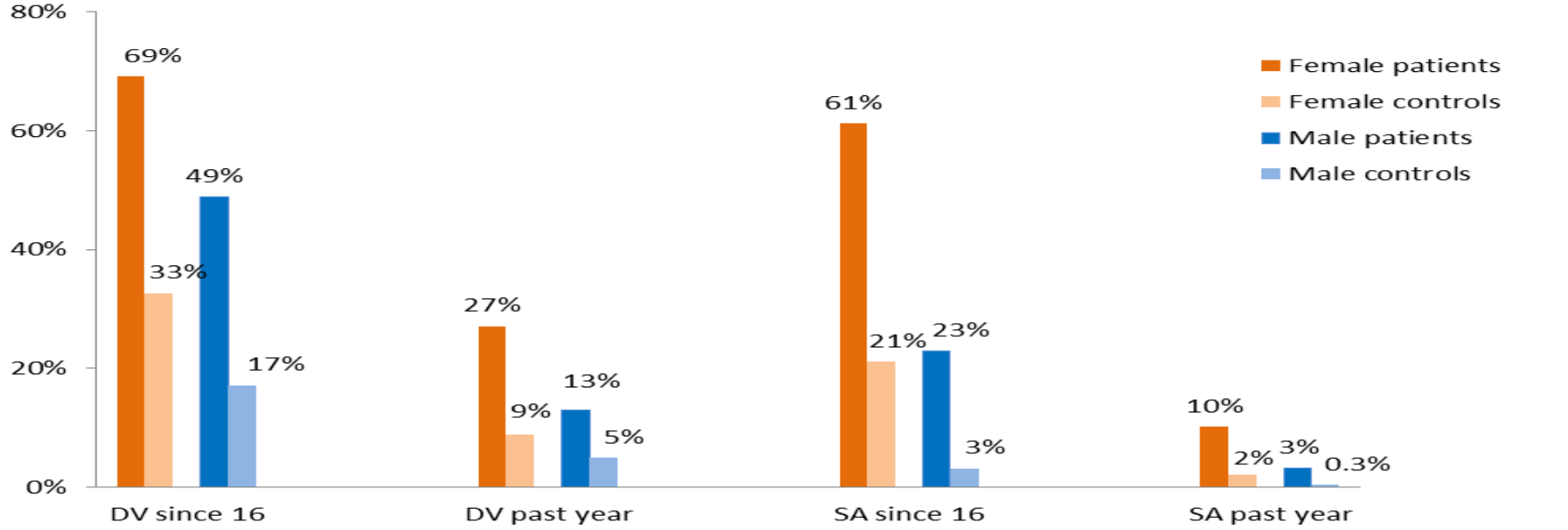
***(Khalifeh et al 2013)***

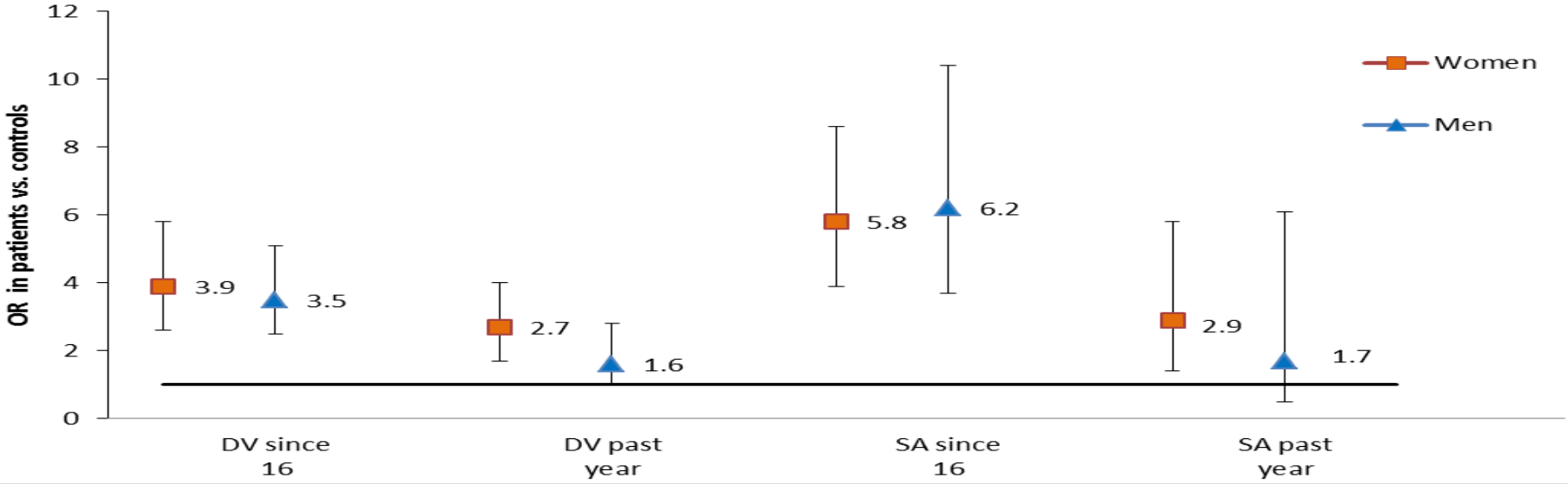
# MHJS Survey: prevalence of victimisation in the last year among patients and controls (face-to-face measures)




*(Khalifeh et al 2013)*

**Fig. 1 Prevalence and adjusted odds for domestic violence (DV) and sexual assault (SA) victimisation**



# MHJS Survey: impact of victimisation

| | Patient<br>% (N) | Control<br>% (N) | Adjusted OR (95% CI) |
|---|---|---|---|
| **EMOTIONAL EFFECT** | | | |
| Perceived as very serious | 17.1 (123) | 6.5 (489) | 4.7 (3.7-5.7) |
| Emotionally affected 'very much' | 31.9 (135) | 21.5 (488) | 3.7 (2.7-4.7) |
| **PHYSICAL INJURY** | | | |
| Injury | 74.2 (66) | 40.7 (123) | 3.5 (1.6-7.7) |
| Medical attention | 20.5 (78) | 12.0 (191) | 0.31 (0.10-0.90) |
| **PREVENTION** | | | |
| Made changes to prevent future victimisation | 55.1 (107) | 67.6 (488) | 0.48 (0.28-0.82) |

***(Khalifeh et al 2013)***

# Establishing Causality

Relationship between domestic and sexual abuse and mental disorders

**Bi-directional relationship:**

- Domestic and sexual abuse can lead to development of mental illness
- Mental illness can create vulnerabilities to abuse

(Chandan et al 2019; Howard et al 2010; Khalifeh et al 2015)

# Response of mental health/social care services to domestic/sexual abuse

# Healthcare responses

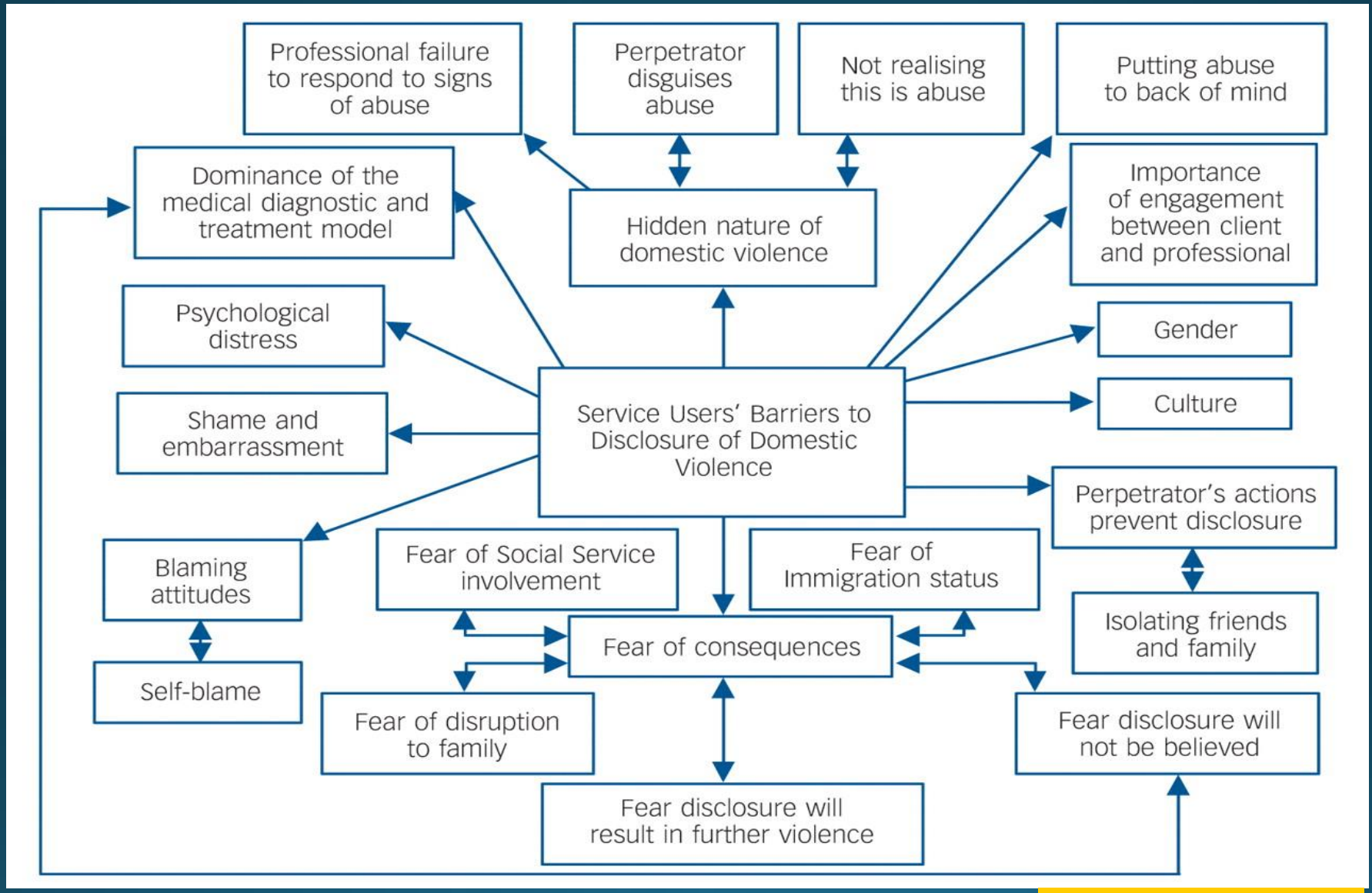
**Review of rates of abuse identification:**

- Low detection rates by mental health professionals (10%-30%)
- Cross-sectional survey of staff in London Mental Health Trust:
  - 15% routinely asked all clients
  - 60% lacked knowledge of support services
  - 27% services lacked referral resources

**Survey of domestic abuse services:**

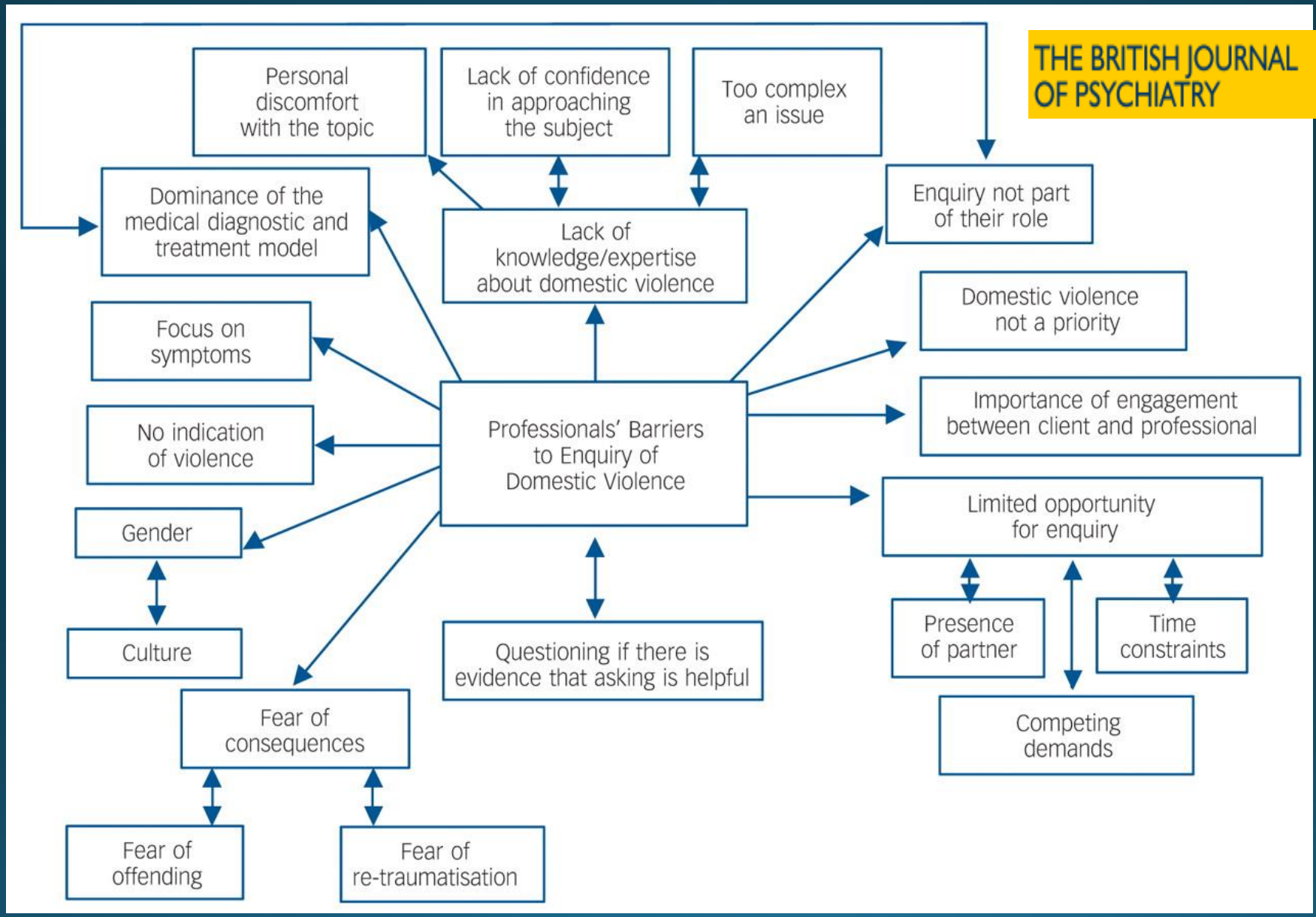
- National UK survey of 216 refuges found that only 19% of services were able to offer refuge to women with mental health needs
- NZ study of 39 Women's Refuges found high numbers of women denied access because of mental health/substance use problems

(Nyame 2013; Howard et al 2010; Hager et al 2006; Barron et al 2004)




**Rose D et al. BJP 2011;198:189-194**


THE BRITISH JOURNAL OF PSYCHIATRY




**Rose D et al. BJP 2011;198:189-194**

# Social Care worker experiences

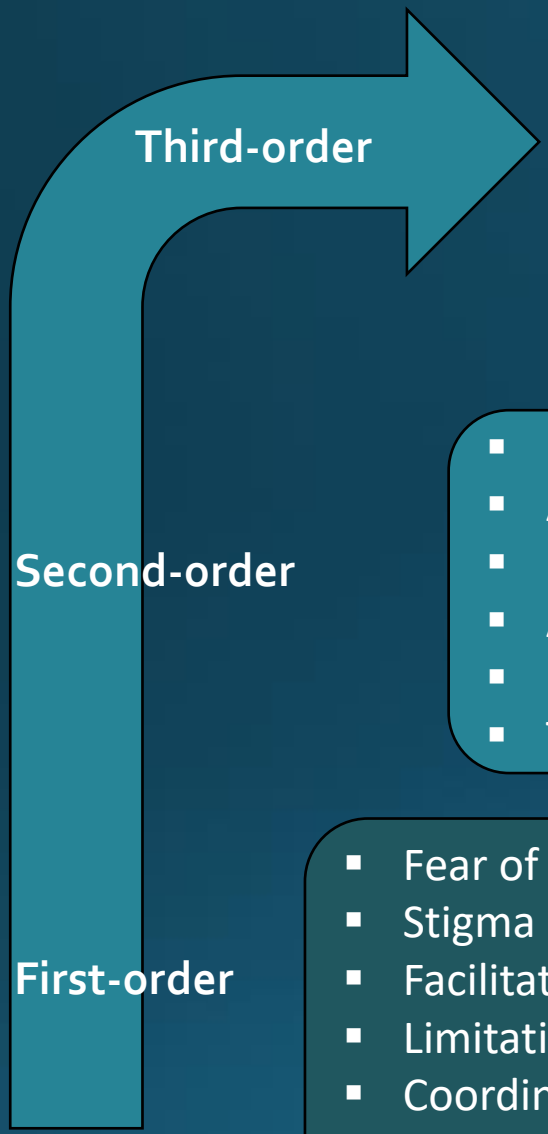
Identify a lack of knowledge and training on how to adequately support families experiencing DVA

Child protection based social workers indicate interventions may not be empowering for mothers (e.g. focus on mother needing to leave abusive relationship, child removal)

Importance of educating mothers and fathers about impacts on DVA on children

(Fleck-Henderson 2020; Moody 2020; Szilassy et al 2013; Witt and Diaz 2019)

# What are the barriers to effective responses?



**Third-order**

- Preparedness to respond
- Supportive environment for disclosure and discussion
- Information to facilitate decision making
- Abuse-informed care

**Second-order**

- Facilitating disclosure
- Attitudes and behaviour of staff
- Identification and reassurance
- Access to domestic abuse services
- Prevention of further abuse
- Training

**First-order**

- Fear of disclosure
- Stigma
- Facilitating discussions of abuse
- Limitations of biomedical model
- Coordinated service delivery
- Safety

Trevillion, K. et al (2014) Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis. International Review of Psychiatry 26, 4 (2014), 430–444

# Measure to address violence

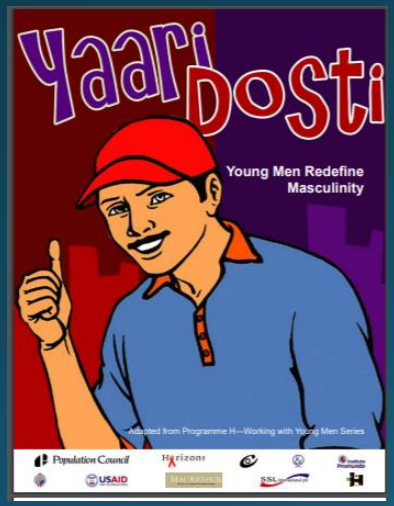
# Public Health Strategies

Awareness-raising, education and information on violence in public sphere



Wexford branch of Soroptimists Ireland




https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=1030&context=departments_sbsr-hiv


http://clok.uclan.ac.uk/2973/1/STCfinal_report_31-5-11_pdf.pdf

Examples of societal-level activities that seek to challenge harmful gender stereotypes

# Policy Initiatives

- Ireland Domestic Violence Bill / new UK Domestic Abuse Bill
- First Domestic Abuse Commissioner in England and Wales
- Department of Justice and Equality: Second National Strategy on Domestic, Sexual and Gender-based Violence (2016-2021)
- Health Service Executive Policy on Domestic, Sexual and Gender Based Violence (2010)
- UK Sexual Assault Referral Centres / Ireland Sexual Assault Treatment Centres
- NHS England guidance on sexual abuse (2018)

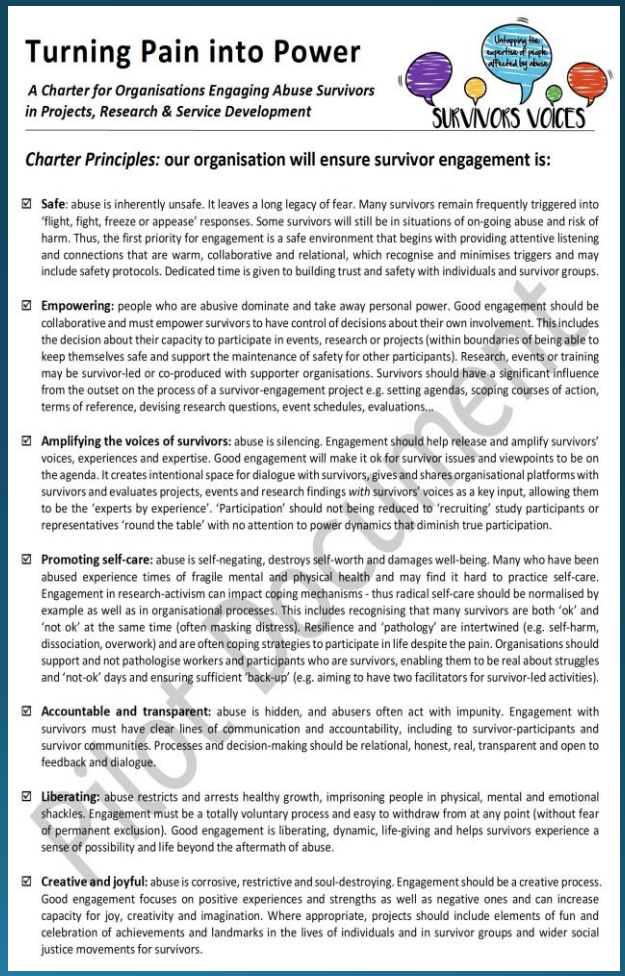
# Create a disclosing environment

- Clearly display information on violence in waiting areas/other suitable places
- Staff training on violence and regular supervision for those working with people
- Ensure people given maximum privacy/professional interpreter
- Establish referral pathways to specialist violence and abuse agencies
- Ensure frontline staff know about the services and referral procedures
- Establish clear policies and procedures for staff who have been affected by violence

# Co-production with survivors

- 7 principles for good survivor engagement
- 7 areas of good practice guidance to encourage active, safe and meaningful involvement of abuse survivors in:
  - Research
  - Development services and projects
  - Development of policy and practice standards
  - Events, training and conferences.

Document accessible from [www.survivorsvoices.org.uk](http://www.survivorsvoices.org.uk)



**Turning Pain into Power**

*A Charter for Organisations Engaging Abuse Survivors in Projects, Research & Service Development*

SURVIVORS VOICES

***Charter Principles:* our organisation will ensure survivor engagement is:**

☑ **Safe**: abuse is inherently unsafe. It leaves a long legacy of fear. Many survivors remain frequently triggered into 'flight, fight, freeze or appease' responses. Some survivors will still be in situations of on-going abuse and risk of harm. Thus, the first priority for engagement is a safe environment that begins with providing attentive listening and connections that are warm, collaborative and relational, which recognise and minimises triggers and may include safety protocols. Dedicated time is given to building trust and safety with individuals and survivor groups.

☑ **Empowering:** people who are abusive dominate and take away personal power. Good engagement should be collaborative and must empower survivors to have control of decisions about their own involvement. This includes the decision about their capacity to participate in events, research or projects (within boundaries of being able to keep themselves safe and support the maintenance of safety for other participants). Research, events or training may be survivor-led or co-produced with supporter organisations. Survivors should have a significant influence from the outset on the process of a survivor-engagement project e.g. setting agendas, scoping courses of action, terms of reference, devising research questions, event schedules, evaluations...

☑ **Amplifying the voices of survivors:** abuse is silencing. Engagement should help release and amplify survivors' voices, experiences and expertise. Good engagement will make it ok for survivor issues and viewpoints to be on the agenda. It creates intentional space for dialogue with survivors, gives and shares organisational platforms with survivors and evaluates projects, events and research findings *with* survivors' voices as a key input, allowing them to be the 'experts by experience'. 'Participation' should not being reduced to 'recruiting' study participants or representatives 'round the table' with no attention to power dynamics that diminish true participation.

☑ **Promoting self-care:** abuse is self-negating, destroys self-worth and damages well-being. Many who have been abused experience times of fragile mental and physical health and may find it hard to practice self-care. Engagement in research-activism can impact coping mechanisms - thus radical self-care should be normalised by example as well as in organisational processes. This includes recognising that many survivors are both 'ok' and 'not ok' at the same time (often masking distress). Resilience and 'pathology' are intertwined (e.g. self-harm, dissociation, overwork) and are often coping strategies to participate in life despite the pain. Organisations should support and not pathologise workers and participants who are survivors, enabling them to be real about struggles and 'not-ok' days and ensuring sufficient 'back-up' (e.g. aiming to have two facilitators for survivor-led activities).

☑ **Accountable and transparent:** abuse is hidden, and abusers often act with impunity. Engagement with survivors must have clear lines of communication and accountability, including to survivor-participants and survivor communities. Processes and decision-making should be relational, honest, real, transparent and open to feedback and dialogue.

☑ **Liberating:** abuse restricts and arrests healthy growth, imprisoning people in physical, mental and emotional shackles. Engagement must be a totally voluntary process and easy to withdraw from at any point (without fear of permanent exclusion). Good engagement is liberating, dynamic, life-giving and helps survivors experience a sense of possibility and life beyond the aftermath of abuse.

☑ **Creative and joyful:** abuse is corrosive, restrictive and soul-destroying. Engagement should be a creative process. Good engagement focuses on positive experiences and strengths as well as negative ones and can increase capacity for joy, creativity and imagination. Where appropriate, projects should include elements of fun and celebration of achievements and landmarks in the lives of individuals and in survivor groups and wider social justice movements for survivors.

# Health-based DVA interventions

- Limited evidence but CBT effective in improving symptoms and self esteem in women who have left abusive relationships
- Review of 13 RCTs involving 2,141 participants to examine effects of domestic abuse advocacy for women in community and primary care settings. Findings:
  - Intensive advocacy (≥ 12 hours) may improve quality of life and reduce abuse
  - Brief advocacy (< 12 hours) may provide short-term mental health benefits and reduce abuse [particularly for pregnant women  with less severe abuse]

*(Trevillion et al 2014; Rivas et al 2015; Kiely 2010; Feder et al, 2009)*

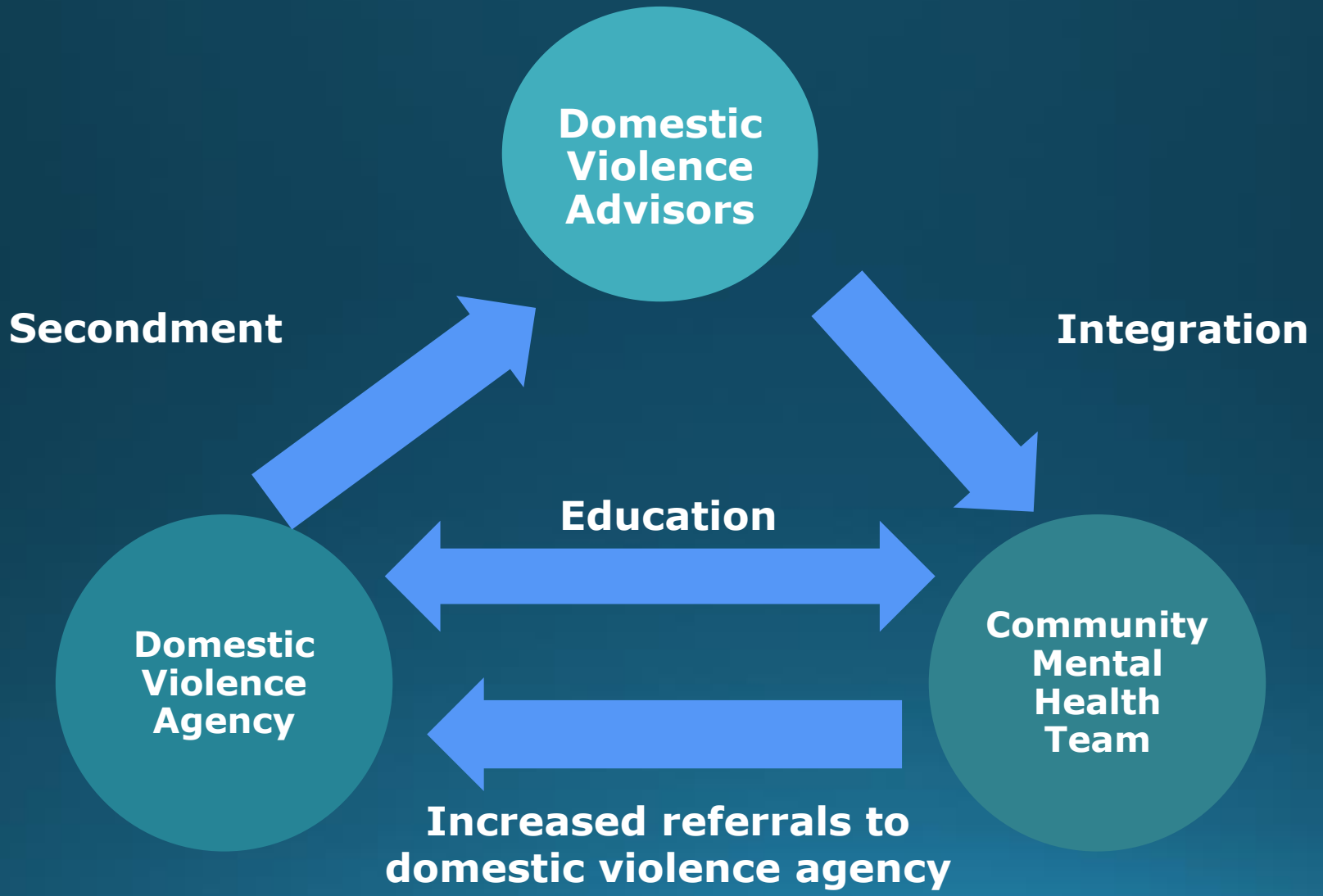
# LARA Study – mental health intervention

Pilot intervention: DVA advocacy in CMHTs

**Aims:**

- Provide training and education to improve knowledge and confidence in responding to needs of service users
- Develop an explicit referral pathway to domestic violence advocacy intervention, via named domestic violence advisors

# LARA Domestic Violence Advisors




*(Trevillion et al 2014)*

# LARA Study

Intervention teams received:

- Four hours didactic teaching, experiential exercises
- Domestic Violence Aware toolkit (e.g. strategies for identification and documentation of abuse, details of support services)
- Bi-monthly domestic violence forums - delivered by LARA advisors
- DVA awareness raising in CMHTs

LARA Study staff outcomes (n=23 intervention arm):

Primary outcomes:

- Improvements in knowledge, attitudes, behaviours ($p<0.05$)

LARA Study Service user outcomes (n=22 intervention arm):

Primary outcomes:

- Reductions in experience of DV ($p<0.001$)
- Reductions in unmet needs ($p<0.05$)

Economic evaluation

- Decrease in hospital service use
- Improved outcomes create small additional costs?

***(Trevillion et al 2014)***

# DVA advocacy in mental health settings

LINKS
Towards a better response to domestic violence & abuse in mental health

**660% increase in referrals -** 5 referrals 2016-2017 vs. 38 referrals 2017-2018

***'it has helped raise awareness, and how domestic abuse works' [staff response]***

*(SafeLives 2018)*

# Health-based interventions for sexual assaults

Regehr et al 2013 "Interventions to reduce distress in adult victims of sexual violence and rape"

- Review of effectiveness of interventions from 6 RCTs involving 358 adults:
  - 3 RCTs of Prolonged Exposure therapy report significant reductions in PTSD, depression and anxiety post-treatment compared to waitlist control [high heterogeneity]
  - 1 RCT of Cognitive Processing Therapy report significant reductions in PTSD and depression post-treatment compared to waitlist control
  - 2 RCTs of Eye-Movement Desensitisation and Reprocessing (EMDR) report significant reductions in PTSD, depression and anxiety post-treatment compared to waitlist control [high heterogeneity PTSD]
  - Conc. some evidence that cognitive and behavioural interventions reduce symptoms of PTSD, depression and anxiety

***(Regehr et al 2013)***

SF
THE STEFANOU FOUNDATION


For Baby's Sake - Whole family DVA programme

Mothers and fathers, who wish to co-parent (from pregnancy to when child is 2 yrs)

Strengths-based model, delivered separately but in a coordinated way (parents move through programme at similar pace)

Utilises therapeutic models (*CBT, motivational interviewing, transactional analysis, gestalt therapies, inner child work, VIG, NBO*)

Integrated and embedded within Local Authorities and safeguarding pathways

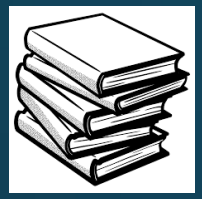
# Evaluation of *For Baby's Sake*

| | |
|---|---|
| **Process data** | To assess whether the programme operates as anticipated |
| **Outcome data** | To examine whether the programme delivers a range of positive short-term outcomes |

(Domoney et al 2018)

## MEN (N=13)

Mean Age 29 (7.7)

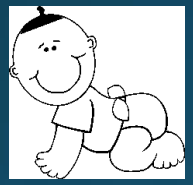


Education – 45% GSCE or no qualifications

Ethnicity – 85% White British

Current smoking – 77%

Marital status – 54% married or co-habiting

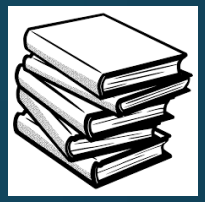


First time parent– 38%

Self-reported mental illness – 54%

## WOMEN (N=27)

Mean Age 28 (7.5)

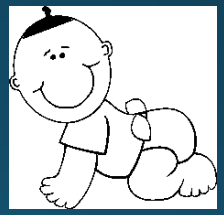


Education – 15% GSCE or no qualifications

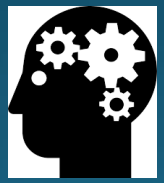
Ethnicity – 75% White British

Current smoking – 29%

Marital status – 37% married or co-habiting



First time parent– 40%



Self-reported mental illness – 44%

# Process Data

- Unique approach targeting DVA impacts in utero
- Three-way therapeutic practitioner approach novel
- Multi-disciplinary teams facilitate shared learnings
- Teams embedded well in sites
- During the evaluation period – 163 families supported across sites
- Men received less parenting-related sessions than women

# Outcome Data

- Reductions in social care involvement with families by end of the programme
- Observed separation of many couples
- Symptoms of depression may reduce among mothers
- Child development outcomes largely in normal range
- Parent-child interactions more varied, with some families continuing to display problems

*https://www.forbabyssake.org.uk/wp-content/uploads/2021/02/FBS-1165-Full-Report-A4-v1-1.pdf*

# Changes in fathers

There’s a lot of things that I’ve seen on this programme where I’ve gone “oh shit, I do that”…they went “shouting insults, comparing, overruling parenting skills, putting them down is domestic abuse…In your head a domestically violence person beats their wife black and blue on a regular basis you

“I don't feel the need to self-medicate in that way, nor do I feel the need to take medication that I was previously taking...So I guess those are two pretty radical changes in my existence that I'm very positive about, very proud of. I think that the programme has facilitated those decisions and those moves.”

“[I’ve] learnt how to self-regulate better and have more self-restraint and communicate more effectively”.

# Changes in mothers

Whether I'm speaking to my inner child or from my critical parent or from my adult self…I found that useful, just to differentiate, kind of, where I'm at

When I signed up, I just wanted to save my relationship. Somewhere in the middle of the course I was completely open with my partner and I was actually able to stand up and say I don't need a man

It's improved my parenting skills, in a way of just how to relate to them, how to speak to them, how to teach them to express themselves

# Views of stakeholders

*They've got a good couple of years to work with the client, whereas if you're in a social work role you've got that six weeks…from that point of view, it's wonderful.*

# Views of staff

*I really enjoy this model of working. I think this is the way forward…because you get so much more of a rounded picture of what's going on. It's not one-sided.*


- The programme successfully embedded within local authority social care settings
- Families who remained in the programme reported positive experiences
- The whole-family approach and the therapeutic content may lead to positive changes

# Key References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# Sources of support

- https://www.safeireland.ie/get-help/where-to-find-help/ (links to resources in each county)
- https://www.womensaid.ie/services/helpline.html 24 helpline , they also do one to one support and have a court accompaniment service
- https://www.mensaid.ie for men who are experiencing domestic abuse
- https://www2.hse.ie/services/sexual-assault-treatment-units/where-to-find.html