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Handbook of Interpersonal Violence and Abuse Across the Lifespan

A project of the National Partnership to End Interpersonal Violence Across the Lifespan (NPEIV)

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With 254 Figures and 107 Tables

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Mental Health Treatment in the Context of Intimate Partner Violence

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Abstract

A large body of research has demonstrated that experiencing abuse by an intimate partner is associated with a wide range of mental health consequences. Some are the direct results of violence, others are related to the traumatic psychophysiological effects of ongoing abuse. Less well researched, however, are the ways that people who abuse their partners engage in coercive tactics related to their partner's mental health or substance use as part of a broader pattern of abuse and control – tactics known as mental health and substance use coercion. For survivors of ongoing Intimate Partner Violence (IPV), responding to trauma raises another set of concerns, particularly when the trauma is unremitting, and symptoms reflect a response to ongoing danger and coercive control. At the same time, many survivors experience multiple types of trauma over the course of their lives, including structural violence and marginalization. While more research is needed on IPV-specific treatment interventions, evidence indicates that interventions that are adapted to meet the specific needs of survivors of IPV are most effective. This chapter provides an overview of the impact of IPV on survivors' mental health and a framework for treatment in the context of IPV, including IPV-specific treatment strategies and suggestions for incorporating an IPV- and trauma-informed approach.

Keywords

Trauma · Intimate Partner Violence (IPV) · Mental health · Mental health and substance use coercion · Traumatic effects · Complex trauma · Trauma-informed · IPV-informed · Mental health coercion · Ongoing risk

Introduction: Intimate Partner Violence, Trauma, and Mental Health

Advances in the fields of traumatic stress, child development, genetics, and neuroscience have generated more complex approaches to understanding the impact of early experiences on subsequent health, mental health, and life trajectories as well as the psychobiological impact of adult trauma. These, in turn, have expanded our understanding of the effects of interpersonal abuse across the lifespan; issues that research on intimate partner violence (IPV) and mental health have also begun to reflect (Felitti et al. 1998; De Bellis and Zisk 2014). Although past approaches failed to appropriately link social context with psychiatric symptoms and disorders, this evolving body of knowledge, particularly when grounded in domestic violence (DV) advocacy perspectives, provides a useful framework for understanding the range of mental health responses experienced by survivors of IPV (Warshaw and Brashler 2009; Warshaw et al. 2009). DV versus IPV is used in this chapter when referring to the DV field.

While viewing the effects of IPV through a trauma lens has been instrumental in shifting clinical paradigms, addressing mental health in the context of ongoing IPV raises an additional set of concerns. For example, survivors and advocates have long been aware of the ways mental health issues are used *against* survivors of IPV, not only by abusive partners but also by the systems in which survivors seek help. A study by the National Domestic Violence Hotline (NDVH) found disturbingly high rates of abuse specifically targeting survivors' mental health and substance use – tactics known as mental health and substance use coercion (Warshaw et al. 2014). Survivors reported that their abusive partners said or did things to make them feel like they were "going crazy"; coerced them into use; withheld prescription medications; discouraged or sabotaged their treatment and recovery efforts; threatened them with withdrawal as a tactic of control; and used their mental health or substance use to discredit them with friends, family, helping professionals, and the courts. Stigma associated with substance use and mental illness and discriminatory system responses – particularly for survivors from marginalized communities – contributes to the effectiveness of these tactics and creates additional barriers when survivors try to seek help. Recognizing the role of mental health and substance coercion and the ability of people who perpetrate IPV to leverage providers and systems against their partners is critical to addressing the complex realties that survivors face as they try to end the violence in their lives and heal from its traumatic effects (Warshaw et al. 2014).

Prevalence of IPV and Other Lifetime Trauma Among People Accessing Mental Health Services

Although attention to victimization among people receiving mental health services initially focused on the long-term effects of *childhood abuse*, rates of *adult victimization* appear to be equal or higher. Across studies, lifetime IPV prevalence rates average 30% for outpatient settings, 33% for inpatient settings, and 60% for psychiatric emergency settings. Cross-setting studies have found current IPV rates of 26% (Oram et al. 2013). In one study, over 70% of women admitted for a first psychotic episode had experienced at least one type of abuse, and 42% reported ongoing exposure (Neria et al. 2002). Rates are lower for men but concerning nonetheless.

IPV and Lifetime Trauma

For many survivors, IPV occurs in the context of other lifetime traumas. Studies have examined the links between IPV and childhood physical and sexual abuse, finding that women who are physically or sexually abused as children or who witness their mothers being abused appear to be at greater risk for victimization in adolescence and adulthood by both intimate and non-intimate perpetrators (Desai et al. 2002).

Studies in both clinical and shelter settings have found high rates of childhood abuse and childhood exposure to IPV among survivors. For people who have experienced multiple types of victimization, IPV increases the risk of developing posttraumatic mental health conditions, including substance use – a common method of relieving pain and coping with anxiety, depression, and sleep disruption associated with abuse (Walsh et al. 2015). These conditions, in turn, may place survivors at risk for further abuse (Warshaw et al. 2009).

Socioeconomic inequities can also expose people to victimization, compounding their risk for developing trauma-related sequelae. People experiencing poverty have the highest risk of being victimized throughout their lives (Goodman et al. 2009; Breiding et al. 2017). Structural inequities, ongoing legacies of historical trauma, and insidious forms of social and cultural victimization (e.g., microaggressions) are also associated with a range of traumatizing effects (Root 1996; Bent-Goodley 2007; Miller et al. 2016; Brockie et al. 2015). While IPV itself is associated with a range of psychological consequences, people living in disenfranchised communities face multiple sources of stress in addition to violence, including discrimination, poorer health status, and reduced access to critical resources, all of which can increase psychological distress (Sotero 2006; Myers, H.F. et al. 2015a).

IPV and Psychiatric Disability

While most survivors do not develop psychiatric disabilities, people living with these conditions are at greater risk of abuse. Poverty, homelessness, institutionalization, unsafe living conditions, and dependence on caregivers exacerbate these risks, increasing targeting by a range of perpetrators – within families, on the streets, in institutional/residential settings, and by intimate partners (Goodman et al. 1995; Warshaw et al. 2009). General population studies have found higher rates of IPV among people living with psychiatric disabilities (Khalifeh et al. 2015; Shah et al. 2018). In addition, IPV is often a precipitant to homelessness (Gilroy et al. 2016), and one study found that a significant majority of women with psychiatric disabilities experiencing homelessness had been abused by an intimate partner (Ramos et al. 2004).

Although psychiatric crises – including psychotic episodes – are often precipitated by recent trauma, clinicians may misinterpret disclosures of abuse as delusions, leaving survivors vulnerable to further victimization. At the same time, abusers may actively try to induce psychotic symptoms by withholding medication, interfering with healthy routines, or coercing their partner to take drugs. Symptoms of trauma can be misattributed to psychotic disorders, heightening the potential for misdiagnosis and treatment that do not address safety needs.

Mental Health Impact of IPV

Research has consistently found that exposure to abuse is a significant factor in the development and exacerbation of psychiatric conditions and influences the course of

recovery (Walsh et al. 2015). Both random population studies and studies conducted in clinical settings indicate that IPV places individuals at significantly higher risk for depression, anxiety, PSTD, eating disorders, chronic pain, insomnia, substance use disorders, suicide attempts, and experiencing greater unmet mental health needs. Experiencing multiple forms of IPV significantly increases this risk (Beydoun et al. 2017; Dillon et al. 2013).

Depression and IPV

Depression is a frequent consequence of IPV (Bacchus et al. 2018). Recency and severity of violence as well as the cumulative burden of trauma, particularly sexual assault and childhood abuse, contribute to the development and severity of depression in this context. People who experience IPV have triple the risk for developing major depressive disorder and nearly double the risk for postpartum depression (Beydoun et al. 2012). At the same time, cessation of exposure to IPV and social support are associated with significant reduction in symptoms (Coker et al. 2002; Warshaw et al. 2009).

Posttraumatic Stress Disorder (PTSD), Complex Trauma, and IPV

Interpersonal violence is associated with higher rates of PTSD than other types of trauma and is more likely to become chronic and of longer duration. This is especially true for women who are more than twice as likely as men to develop chronic PTSD (Breslau et al. 1997). Rates of PTSD among women survivors of IPV are estimated between 45% and 84% with a weighted mean prevalence across studies of 61% (Dejonghe et al. 2008). Data also suggest that PTSD risk increases with the duration and severity of abuse and the number of types of IPV experienced, including psychological abuse and sexual violence, which carry independent risks. Lower levels of social support have also been associated with higher rates of PTSD among women experiencing IPV (Coker et al. 2004). In addition, survivors frequently experience additional layers of stress not captured by PTSD diagnostic criteria but which nonetheless contribute to symptoms (Kaysen et al. 2003; Warshaw et al. 2009).

While cross-sectional studies provide a window into symptoms that are present at a time of crisis, several longitudinal studies have looked at the course of PTSD among survivors of IPV. One study found that while 42% of women in shelter met criteria for PTSD, only 14% did so one year later (Mertin and Mohr 2001). As with depression, safety and social support contribute to improvement in PTSD for some individuals (Johnson and Zlotnick 2012). For others, PTSD becomes chronic and may benefit from more intensive treatment (Johnson et al. 2011). For individuals who are still at risk, symptoms may be an adaptive response to ongoing danger and coercive control. For many survivors, the abuse may continue long after they have

left – through stalking, prolonged divorce or custody hearings, visitation, and retraumatization by legal and/or other systems (Davies and Lyon 2013).

Although less well studied, survivors of IPV may also experience more complex posttraumatic responses, particularly if they were abused in childhood, if the IPV is more prolonged and severe, and/or if they experienced polyvictimization. Childhood abuse and entrapment in an abusive relationship are qualitatively different from many other types of trauma. As several authors describe, they are premeditated, ongoing, and most often perpetrated by someone whom the person being victimized is attached to and dependent upon (Courtois and Ford 2016). Collective forms of trauma also involve betrayal of trust, loss of resources, and disruption of traditional community supports. Complex trauma approaches take into account the multiple aspects of people's sense of self and community that can be impacted by trauma – aspects which are also important to survivors of IPV (Warshaw et al. 2013).

IPV and Suicide

IPV significantly increases suicide risk among adolescents and adults (Silverman et al. 2001; Devries et al. 2013), with rates of suicidal ideation and attempts found to be three and four times higher among women who have experienced IPV (Dillon et al. 2013). In community samples, 23% of women experiencing IPV reported a past suicide attempt versus 3% without a history of IPV, and 36.8% of IPV survivors seriously considered suicide (Pico-Alfonso et al. 2006). Likewise, higher rates of IPV have been found among women with suicidal ideation or attempts. A 2002 study by Thompson et al. reported that African American women who attempted suicide were 2.5 times more likely to have experienced physical abuse and 2.8 times more likely to have experienced emotional abuse by an intimate partner than demographically similar women who had not been abused. In another study, over 90% of women hospitalized with suicidal ideation reported current and severe IPV (Heru et al. 2006).

Mental Health Treatment in the Context of IPV

Mental health care for survivors of IPV involves a combination of specific interventions related to safety, confidentiality, access to resources, and treatment for the range of symptoms associated with abuse. While important strides have been made in trauma treatment, research specifically addressing treatment for survivors of IPV remains limited. Over the past 40 years, however, treatment recommendations have evolved into consensus models of care that can be integrated into appropriate evidence-based and/or emerging multi-dimensional treatment approaches (Warshaw and Brashler 2009).

Preparing to Address IPV

Integral steps in preparing to address IPV include becoming knowledgeable about the dynamics of abuse; adopting a culturally responsive, trauma-informed approach (Warshaw et al. 2018a); centering survivors' self-defined goals and concerns; developing relationships with local DV experts; and attending to safety and confidentiality.

Incorporating an Accessible, Culturally Responsive, IPV/Trauma-Informed Approach

Specific elements of welcoming practice environments include: displaying materials that reflect the range of cultures and communities being served, ensuring full accessibility (language, sensory, cognitive, mobility, etc.), proactively creating a diverse and representative workforce, and working in collaboration with community-based groups to ensure that services reflect self-defined community needs. Policies and practices that support clinicians' efforts to address complex issues; that provide adequate supervision and peer support; and that allow for the provision of more time-intensive treatment modalities, resource advocacy, and cross-sector collaboration are also key (Warshaw et al. 2018a).

Culture influences how individuals experience and describe symptoms, the complexity of stressors they may encounter, strategies for seeking help, coping styles, and sources of social support (Satcher 2001). Culturally responsive approaches include welcoming survivors' experiences of culture as they define it and creating opportunities to discuss how culture influences their perceptions of abuse, access to services, response to interventions, perspectives on staying with an abusive partner, the constraints they may face in leaving, and sources of meaning and support (Warshaw et al. 2013).

An IPV/trauma-informed approach recognizes how a survivor's individual and collective history as well as threats to current safety can affect their symptoms and presentations, their experience of clinical relationships, and their responses to treatment, while also taking a de-pathologizing stance that focuses on resilience and strengths. Symptoms are understood as adaptive responses to intolerable experiences and/or a realistic response to ongoing danger. For example, observations of hyperarousal or hypervigilance may be necessary survival responses to ongoing threats. Holding an empathic understanding of coping strategies that survivors experience as shameful can also reduce the likelihood of responding in ways that are damaging to the therapeutic alliance, which is central to the process of healing. Self-awareness, consultation, and peer support are all features of this approach, enhancing the prospect for therapeutic success by addressing the impact of this work on providers (Warshaw and Brashler 2009).

Incorporating a DV-Advocacy Approach in Clinical Services

Consistent with recovery-oriented approaches, IPV-informed treatment is rooted within a DV-advocacy framework that centers survivors as the experts on their own lives. This includes facilitating (rather than directing) change by helping survivors to become aware of their options and gain access to resources while

supporting their decision-making. While motivational approaches can help individuals to address symptoms arising from behavioral health conditions, empowerment-based approaches that support survivors' decisions and choices are better suited to the context of IPV. Helping a survivor to understand the roots of his or her current feelings, symptoms, and situations, or working on changing cognitions and behaviors they feel are getting in their way can be helpful in the right context. These same approaches can be harmful when they are misapplied, particularly in the context of ongoing IPV. The influence of earlier abusive relationships on survivors' abilities to find safe and mutually respectful relationships as adults is better addressed when they are no longer under siege by an abusive partner. Timing and sensitivity are critical so as not to increase self-blame (Warshaw and Brashler 2009).

Attending to Privacy and Confidentiality

While assessment is often considered the first phase of treatment, disclosure of abuse can pose risks to survivors. People who perpetrate IPV are skilled at manipulating the systems their partners turn to for help, so all clinical and documentation procedures should be considered through the lens of safety to guard against practices that increase survivors' risk. Strengthening confidentiality practices and communicating the limits of confidentiality are necessary for survivors' safety. How information is collected, stored, used, and reported for billing purposes, as well as how records can be accessed and by whom, are important to clarify as a part of informed consent to treatment. Given the risks survivors face in disclosing IPV, it is important to provide access to information and resources without requiring self-disclosure (Warshaw and Tinnon 2018).

Because disclosure carries the risk of retaliatory violence, asking about IPV requires that measures be taken to maintain privacy and confidentiality. Consensus guidelines are clear with regard to not asking about abuse in the presence of someone who may be abusive or in the presence of another person they have not privately identified as safe (Warshaw and Brashler 2009). In addition, questions should not be asked during a couple's therapy session in the presence of a person providing collateral information (even if an individual is unable to speak for themselves at the time) or in mailed or online forms. Because people who perpetrate IPV often resist being separated from their partners, strategies for safely separating individuals from accompanying parties prior to inquiry about abuse should be developed in advance. At the same time, a person's desire to have their support person present must be respected. If the person declines being interviewed individually, then questions about potential abuse should not be raised at that time. If an individual calls on the phone, establish whether or not it is safe for them to discuss these issues using yes/no questions before inquiring about abuse (Warshaw et al. 2018b).

Attending to Physical and Emotional Safety

Safety is paramount for all survivors of abuse. This means considering physical and emotional safety within the treatment setting, as well as when travelling to and from the site.

Survivors consistently report that the quality of the clinical interaction impacts how they respond to questions about abuse. The experience of being treated with respect can be therapeutic in itself. Clinical interactions can provide an opportunity for survivors to experience others as trustworthy and safe, to counter abuse-related dynamics they may have internalized, and to regain a sense of connection with themselves and others. Establishing trust may be part of a much longer therapeutic process, particularly for those whose trust has been continually betrayed (Courtois and Ford 2016). Clinicians can cultivate emotional safety by communicating in ways that help to destigmatize symptoms, normalize responses to abuse, and offer information, choices, and hope. The power imbalances inherent to clinical interactions require conscious attention. Survivors are particularly attuned to relational dynamics. This is of particular concern for clinicians who use directive treatment modalities or work in settings that require adherence to a specific treatment plan. Reflective supervision is essential for supporting collaborative clinical care.

Intake and Assessment

Routine Inquiry and Assessment

Because presentations of IPV vary, inquiring only when abuse is suspected will result in missing significant numbers of individuals who are at risk. Many survivors are still in danger at the time they seek help. Assessing ongoing safety and risk for harm is essential when working with survivors and should be incorporated into initial and ongoing assessment. Resources on danger assessment and safety planning can be found at www.dangerassessment.org and Davies and Lyon (2013).

Numerous studies have demonstrated that the manner in which clinicians ask about abuse and how clinicians respond to disclosure impact a person's level of comfort in discussing these issues (Feder et al. 2006). While it is critical to establish privacy before inquiring about current IPV, being alone in a room with the provider may act as a trauma reminder, particularly for a person who experienced abuse by someone in a caregiving role. Hearing "what goes on between us will not leave the room," may be frightening, rather than reassuring, to someone who was sexually abused as a child (Harris and Fallot 2001). For others, routine history taking may feel like an interrogation. Discussing these issues at the outset and providing options for how to proceed can help to mitigate some of these concerns.

Incorporating Awareness of IPV and Mental Health Coercion into Assessments

There are many ways to integrate conversations about IPV into assessment processes that communicate to individuals that this is a common experience, that they will not be judged, and that there are resources available that can help. Framing questions can provide information about IPV even when a person chooses not to disclose at the time. Descriptive questions about specific forms of abuse that avoid the use of labels help people to recognize abuse patterns, rather than putting them in a position of trying to decipher whether their partner's behavior qualifies as "abusive." For any

- ❒ Has your partner deliberately done things to make you feel like you are "going crazy" or "losing your mind?"
- ❒ Has your partner ever done things to cause your mental health symptoms to get worse or kept you from routines that are healthy for you?
- ❒ Has your partner ever interfered with your treatment, controlled your use of medications, or sabotaged your mental health in other ways?
- ❒ Has your partner blamed you for their abusive behavior by saying you're the one who is "crazy"? Has your partner ever used your mental health to blame you for their behavior?
- ❒ Has your partner used your mental health or substance use condition as a way to discredit you with other people or to justify their behavior? Does your partner tell you no one will believe what you say because of your mental health condition?
- ❒ Has your partner threatened to take your children away because you are receiving mental health treatment?
- ❒ Have you ever been afraid to call the police for help because your partner said you would be arrested or that your children would be taken away?

For more information on how to ask about and respond to mental health and substance use coercion, see: **Coercion Related to Mental Health and Substance Use in the Context of Intimate Partner Violence: A Toolkit for Screening, Assessment, and Brief Counseling in Primary Care and Behavioral Health Settings.**

Fig. 1 Questions about mental health coercion that can be folded into routine assessments

person in imminent danger, safety concerns need to be attended to along with facilitating access to a DV-hotline or program, where survivors can be connected with supports that help increase safety. Because mental health coercion is insidious and pervasive, these questions can be used to specifically address this kind of abuse. See Fig. 1.

It is important to assess the pattern of abuse and the level of control their abusive partner has over their lives. Working together to identify patterns related to the degree of control, isolation, and fear, as well as identifiable signs of impending violence, can elucidate the ongoing nature of the abuse both for the clinician and survivor. That said, providers will need to pace these conversations and allow them to organically unfold over time as a trusting therapeutic relationship is developed.

Previous Trauma History

The timing of questions about abuse experiences should be geared toward an individual's ability to respond without being overwhelmed, particularly if they are currently experiencing a crisis. While inquiry about trauma is an integral aspect of a comprehensive assessment, it may be more effective to ask a general question during the initial assessment process, such as "Are there other painful or frightening experiences that you think may be related to how you are feeling now?" While some people may seek treatment for symptoms explicitly related to a particular traumatic experience, not everyone will link their current distress to such events. A less invasive way of addressing trauma during an initial assessment is to ask individuals about potential symptoms (such as flashbacks or nightmares) which can be addressed in treatment planning, rather than directly asking about previous traumatic events. Because conducting a trauma history can be retraumatizing, informing individuals of what will be asked and why, checking to see if they are

comfortable proceeding, attending to signs of trauma activation, and ensuring that they have someone to talk with should the need arise, are critical (Warshaw and Brashler 2009).

Coping and Survival Strategies

A key component of empowerment-based interventions involves discussing a survivor's abilities and skills, as well as sources of strength and support. Providers can help survivors identify the strengths they use to survive and resist abuse and reframe perceived weaknesses as survival strategies. A strengths-based assessment provides a more holistic understanding of the individual and provides an opportunity to recognize their beliefs, hopes for creating a better life, and persistence in the face of uncertainty and fear (Warshaw and Brashler 2009).

Incorporating IPV-Specific Interventions into Mental Health Practice

Offering Information

Sharing information about the dynamics of abuse and available resources can help decrease isolation, shame, and psychological entrapment while offering a sense of hope and connection. Information about trauma and the impact of abuse can help survivors gain perspective on their own responses and address internalized stigma, which, in turn, facilitates the development of coping skills. Noncoercive information sharing entails asking permission before providing information, as well as making written materials available for individuals to access without self-disclosure. When offering written materials, help individuals consider whether it is safe to keep them. Some may need assistance erasing their digital footprint or using devices other than their own when accessing digital materials (NNEDV 2011).

Addressing Mental Health Coercion

Since many abusive tactics are directed at sabotaging treatment engagement and recovery, clinicians need to be able to counteract these tactics as part of treatment. Approaches that dispel stigma are crucial to neutralizing an abusive partner's use of stigma to demean, control, and isolate their partner. In practice, flexibility with rescheduling, strategizing around safer appointment times, considering alternate modes of engagement (e.g., telehealth), and support with maintaining control of prescriptions, are critical to safety when a person's efforts to engage in treatment are being sabotaged or could increase their risk of being stalked (Warshaw and Tinnon 2018).

Trauma Treatment in the Context of IPV

While there are numerous interventions designed to support recovery from interpersonal trauma, most are designed to address past trauma. Responding to trauma in the context of IPV raises an additional set of concerns, particularly when survivors are

still at risk. In addition, mental health coercion can limit realistic treatment options (Warshaw et al. 2013).

Although rigorously evaluated treatments designed specifically for survivors of IPV are still limited, there are a number of evidence-based interventions that have shown efficacy in reducing depression and PTSD among survivors. Similar to the trauma treatment literature in general (Bisson et al. 2013), treatment modalities empirically tested with survivors of IPV have largely drawn on traditional cognitive behavioral therapy, prolonged exposure therapy, and interpersonal therapy, in addition to a handful of studies of mind-body practices, dialectical behavioral therapy, eye movement desensitization and reprocessing, and interventions designed to support parents of children exposed to IPV. Outcomes are significantly enhanced when interventions are: specifically adapted for IPV, delivered individually, and treatment length is longer (Arroyo et al. 2017). Few interventions, however, are designed for survivors from culturally specific communities (Warshaw et al. 2013) or address, "the complexity of responding to IPV in real-world settings" (Arroyo et al. 2017; Hackett et al. 2015).

This raises the question of what kinds of adaptations would make the most difference, and what are the real-world complexities that are important to factor into effective trauma treatment. A number of key elements have been identified as important to survivors, including attention to: (1) ongoing risk and coercive control as well as specific barriers survivors face; (2) the cumulative effects of trauma across the lifespan, including collective trauma; and (3) culturally specific values, priorities, and concerns (Warshaw et al. 2013).

Ongoing risk and coercive control. For a number of interventions, this includes identifying risks to safety, establishing safety self-care and protections, and conducting safety check-ins, as well as providing financial and legal supports (Johnson et al. 2011; Sullivan and Bybee 1999; Hansen et al. 2014; Dutton et al. 2013). Some include modules on specific issues identified by survivors as important to their recovery, such as strategies for handling future contact with an abusive partner (often related to joint or contested custody) and strategies for preventing future abuse (Kubany et al. 2004). None specifically addresses the more complex risks survivors face (e.g., housing and economic insecurity, legal issues, etc.) – aspects that DV advocates are generally more equipped to take on (Harb et al. 2018).

Cultural considerations. Ensuring access to interventions that are culturally meaningful is another key treatment priority. Given that identities are often multilayered, "culture" has different meanings and resonates in different ways for individuals across time. For some, trauma reminders may be embedded in cultural experiences. For others, culturally specific approaches may be more transformative, particularly when a person's own sense of well-being is integrally tied to the well-being of their family and community (Packard 2016).

Cumulative trauma. While many survivors have experienced multiple types of trauma, only a few IPV-specific interventions directly address these issues. Complex trauma treatment approaches address an array of trauma effects and offer more nuanced approaches to healing, with more meaningful outcomes. Originally

designed for survivors of childhood abuse and neglect, they appear to be helpful to IPV survivors as well, particularly those whose experiences of abuse have been more prolonged and severe. Complex trauma models attend to many of the domains that can be affected by interpersonal trauma, although they generally do not address IPV-specific concerns. However, there are now several IPV-specific interventions that have incorporated a phase-based complex trauma approach (Hansen et al. 2014; Johnson et al. 2011) or modifications thereof (Covington et al. 2008). Two interventions that have been successfully used with adult survivors of childhood trauma have also been adapted for survivors of IPV: Seeking Safety (Myers et al. 2015a) and DBT (Iverson et al. 2009). Both emphasize safety and stability as a first step accompanied by the development of skills. Given that establishing safety and stability are so critical for IPV survivors, these approaches may be particularly applicable for survivors who are still at risk.

All of this speaks of the importance of safety prior to engaging in more intensive trauma work. At the same time, for some survivors, it is the trauma-focused work that makes it possible to establish safety and stability. Studies are still needed to understand the range of factors that contribute to healing, their optimal sequencing, how they can be adapted to meet individual circumstances, as well as whether there are differences in treatment effectiveness for survivors who have experienced other types of trauma, including collective trauma. A number of communities have mobilized to address the intersecting issues of IPV and ongoing legacies of historical trauma and structural violence (Warshaw et al. 2013). Under these circumstances, healing is often inextricably linked with transformative justice and the knowledge that creating safety, stability, and healing is not just the responsibility of individual survivors.

Parenting Support and Child Well-Being

People who perpetrate IPV often actively try to undermine their partners' relationships with their children, creating risks for children's development and their physical and mental health. While exposure to IPV can impact children's well-being and increase the risk for child welfare involvement, research consistently shows that attachment to the non-abusive primary caregiver is most protective of children's resilience and development. Research has also shown that prevention and early intervention efforts are effective in reducing child abuse and IPV. Clinicians can support parenting by affirming and documenting survivors' efforts to safeguard their children, as well as employing interventions that support parent-child attachment (Lieberman et al. 2005).

Collaborating with the DV Field

The DV field is an important resource in a survivor's overall strategy for accessing safety and support. DV advocates are well positioned and experienced in linking to safety resources, including shelter, legal protections, and ways to be safer if survivors remain at home. Advocates routinely support survivors who need to interface with complex systems, including child protective services, public aid, immigration remedies, and legal systems. Developing working relationships with DV programs can also

support clinicians and increase the likelihood that survivors will receive the range of services they need. Not all DV programs have the resources to shelter individuals with more acute mental health symptoms. However, working closely with a mental health provider can make a difference in the extent to which shelters are able to serve survivors who are experiencing mental health needs (Phillips et al. 2020).

Safety Planning and Crisis Response

Safety Planning

Most clinicians are already familiar with helping individuals to develop strategies for keeping themselves safe at times when symptoms present increased risks; a person who is being targeted by an intimate partner can also benefit from having someone to work with in analyzing their situation, identifying risks, and thinking through specific strategies to increase their safety. Safety planning strategies are based on the consensus experiences of survivors and advocates with more than 30 years. Research on this issue is limited, but there have been some randomized controlled trials indicating positive effects (Sullivan 2017).

While DV advocates are important resources for safety planning, clinicians can support survivors by helping to assess danger, discuss options, and access DV resources. If a survivor is in immediate danger, DV hotlines are accessible 24/7 and can assist with safety planning.

Safety planning is an ongoing process that responds to changing circumstances. While having a written plan may be useful for a given survivor, clinical documentation should be more circumspect (e.g., "Strategies for increasing safety were discussed. . . client will continue to weigh the risks and benefits over time."). Written safety plans should not be incorporated into formal treatment plans or placed in a clinical record since these can be used against survivors (Warshaw and Brashler 2009).

For survivors who are living with a disabling psychiatric condition, there are a number of additional dimensions to consider. Safety planning may need to address safety from members of their social network as well as by a partner. In addition to addressing physical, emotional, and sexual safety, it should attend to potential mental health coercion, including guardianship and advance directives. Plans need to be developed based on the individual's cognitive strengths, while taking into account what strategies and language will remain clear during a crisis. Examples include: using simpler, more concrete language; using teach-back methods to check that the provider is using understandable language; helping them to recognize early signs of dissociation and identifying strategies they can use to bring themselves back; or helping people develop ways to self-soothe if anxiety is making them difficult to concentrate (Harris and Fallot 2001).

Psychiatric Advance Directives

A psychiatric advance directive (PAD) is a tool that can be utilized in conjunction with safety planning so that survivors can designate whom they do and do not want

to be informed about and/or involved in their treatment, and who they want named as the attorney-in-fact to make decisions on their behalf if they are unable to do so. PADs also delineate treatment modalities that are or are not acceptable to them if they are ever in a position where they are unable to make these decisions for themselves. As a part of safety planning, it is important to find out if a survivor already has a PAD and if so, who is the designated attorney-in-fact and what their relationship is to the abusive party.

While mental health crisis assessment involves determining whether an individual poses *a danger to* themselves or others, crisis evaluation should also assess whether a person is *in danger from* others. If a person states they are in imminent danger from another person, addressing immediate safety needs takes precedence. Asking questions that can be answered with a "yes" or "no" may be safer in situations when the person is communicating via phone and it is unclear whether they are alone and can safely discuss their situation.

Suicide Risk

Given the relationship between IPV and suicidality, clinicians need to apply awareness of IPV to interventions in suicidality. For example, from a suicide crisis line perspective, asking if the caller is alone and then discovering that someone is there with them may come as a relief. However, from an IPV perspective, the person who is with them might be an abusive partner or family member who may, in fact, be contributing to the crisis and making the caller less safe. Similarly, a third-party caller may seem genuinely concerned about their partner's suicidality, requesting advice about what to say as well as information about how to access inpatient psychiatric services. While this level of concern and support can be both reassuring and helpful in marshaling a plan for safety and support, from an IPV perspective, however, the caller might be an abuser who is trying to have their partner committed as a tactic of intimidation and control and/or to undermine their partner's ability to retain custody of their children (Warshaw et al. 2018b). Recognizing how IPV can play out in a suicide crisis provides additional perspectives for listening and responding to individuals who are dealing with both suicidality and IPV. When assessing plans and means for attempting suicide, it is important to consider what medications may have been prescribed to the survivor given that survivors experience higher rates of chronic pain and are more likely to be prescribed opioid analgesics and other psychotropic medications, which in turn may contribute to overdose risk and suicide (Oquendo and Volkow 2018; Balousek et al. 2007).

Homicidality

Homicidal ideation also warrants emergency psychiatric evaluation. Actual homicide attempts by survivors against an abusive partner are not common. In the majority of cases, survivors who kill their partners have been severely abused for long periods of time, feel that they are in imminent danger, and believe they have no other choice to prevent the murder or serious injury of themselves or their child(ren). Assessing a survivor's level of risk from their abusive partner and discussing safer alternatives can help diffuse the immediate danger (Velopulos et al. 2019). As with a

suicide assessment, the clinician assesses whether the survivor has a plan and access to the means to carry out that plan. When survivors perceive homicide as their only option for safety, discussing other options available to them may help the survivor rescind homicidal intent and contract for safety. If the person does have a plan, "duty to warn" considerations come into play. When the survivor's intent to harm is a desperate means of self-defense, clinicians must intervene to protect *the survivor* as well as the target of their homicidality (i.e., their abusive partner). Discussing the possibility of safety measures such as being transported to out-of-state shelters, relocation, witness protection plans, and temporary hospitalization can provide alternatives to homicide when it is driven by the need for protection. In fact, as safer alternatives for survivors have become more prevalent (i.e., shelter, police/court services), homicides of male perpetrators of IPV have decreased.

Best Practices for Clinical Documentation

Documentation practices that protect the individual's confidentiality are essential, regardless of whether the provider is aware of any history of IPV. Any information that becomes available to a person who abuses his or her partner can increase that person's danger, including their location, the fact that they are seeking treatment, and/or that they disclosed the abuse.

Documentation of IPV and its behavioral health consequences can be of help if their behavioral health becomes an issue in a legal case, particularly in custody proceedings, divorce settlements, civil damages, or immigration cases. Collaborative documentation practices can foster transparency and empowerment. It is especially important for individuals whose information may be used against them to be able to access and contribute to their clinical records. Be mindful of how diagnoses and medications might be used against the survivor. It is important to document descriptions of abusive experiences in a person's own words, particularly when there is the potential for legal action. Documentation should reflect how symptoms result from or are exacerbated by the abuse, as well as the potential for them to subside once the person has access to safety, resources, and support. Providers should document any attempts by an abusive partner to interfere with the survivor's treatment, as well as any attempts to influence the provider's perception of the survivor. Documentation should also describe an individual's strengths, coping strategies, ability to care for their children, and the efforts they have made to protect them. Indications of their parenting ability and the child(ren)'s attachment to their non-abusive parent (e.g., observations of interactions with their child(ren), discussions that demonstrate their attunement and concern) should also be clearly documented. Good documentation and informed consent can help mitigate issues when records are subpoenaed; however, protecting sensitive information is always critical given ongoing stigma and the risks posed by an abusive partner (Warshaw and Tinnon 2018).

Key Points

- IPV is associated with a range of mental health consequences, including depression, PTSD, chronic pain, substance use, and suicidality.
- There are high rates of IPV among people accessing mental health treatment.
- For many survivors, these issues resolve with increased safety and support, but others benefit from additional resources and IPV-informed, trauma treatment.
- People who are living with psychiatric disabilities are at greater risk for abuse and for developing a range of additional trauma-related conditions.
- Understanding the dynamics of IPV and the strategies people who perpetrate IPV use to control their partners, including mental health coercion, are essential for working with survivors of IPV.
- Stigma associated with mental illness reinforces abusers' abilities to control their partners, undermine them in custody battles, and discredit them with friends, family, law enforcement, child protective services, and courts.
- Both physical and emotional safety in the context of mental health treatment are primary concerns for survivors of IPV.
- A combined IPV-trauma framework is most helpful for understanding mental health symptoms in the context of ongoing trauma, entrapment, and danger.
- Issues of culture, marginalization, historical and systemic oppression, stigma, shame, context, community, and spirituality play important roles in survivors' lives and need to be taken into account.
- Survivors face many obstacles in trying to leave an abusive relationship and/or to maintain their safety, credibility, and connections with others in the face of ongoing abuse.
- IPV is not a psychiatric condition. There is no single treatment modality that will meet the needs of all survivors.
- There is limited research on mental health treatment in the context of ongoing IPV. Current best practice approaches involve combining IPV-specific interventions with evidence-informed trauma treatment. Additional research is needed to assess the types of interventions and treatment modalities that are most helpful to survivors of IPV.
- Integral steps in addressing IPV in mental health practice include implementation of accessible, culturally responsive, and trauma-informed approaches; understanding the dynamics of IPV; recognizing the role of mental health coercion; centering survivors' self-defined goals and concerns; attending to safety, privacy, and confidentiality; and developing partnerships with DV providers.
- Maintaining confidentiality within the confines of the law and providing IPV-appropriate documentation are critical to survivors' safety.
- Recognizing the need to play an advocacy as well as clinical role may be a new concept for clinicians but supporting individual survivors as well as promoting advances in policy and practice is integral to improving mental health care and preventing future violence and its long-term effects.

Summary and Conclusion

Working collaboratively with other systems to create the kind of society that will stop interpersonal violence and prevent its traumatic sequelae is vitally important. Mental health providers have a significant role to play in voicing concerns about the impact of abuse and violence on the lives of individuals they work with clinically. Working with people who have survived unthinkable trauma teaches us about the complexity and unpredictability of human life, the intersections among individual biology, human development, social and cultural contexts and larger societal norms, and the importance of caring, respectful human interactions. In working toward social justice, it is also necessary to incorporate an understanding of how the traumatic effects of social *injustice* can play out in both interpersonal and institutional forms. Mental health providers can play a critical role in preventing IPV in addition to treating its consequences by actively addressing the social as well as psychological conditions that create and support this kind of violence.

Offering mental health treatment in the context of IPV also raises a number of policy and practice concerns. First is the need to ensure that mental health services incorporate an understanding of the dynamics of IPV; the impact of mental health coercion; and the range of issues survivors face related to safety, confidentiality, parenting, custody, legal issues, immigration status, stigma, discrimination, economic stability, housing, and social support, all of which influence how a survivor is affected and what options are available to them. Second is the need to change the way that symptoms and disorders are currently viewed, documented, and reimbursed to incorporate a recognition of the direct impact of an abusive partner's behavior as well as the traumatic effects of abuse. While trauma treatment models focus on the impact of abuse and healing from its traumatic effects, advocacy approaches focus on social context and on changing the conditions that place survivors in jeopardy. Responding to a person who is experiencing the mental health effects of IPV and other trauma requires attention to both these domains. This, in turn, underscores the need for the widespread incorporation of approaches to mental health practice that are IPV- and trauma informed.

Cross-References

- ▶ Examining Interpersonal Violence from a Trauma-Informed and Human Rights Perspective
- ▶ Intersectionality
- ▶ IPV: Mental Health Response
- ▶ Trauma Informed Care
- ▶ Treatment of PTSD in IPV Survivors

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