Mental Health and Substance Use Coercion Surveys

Report from the National Center on Domestic Violence, Trauma & Mental Health and the National Domestic Violence Hotline

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The National Domestic Violence HOTLINE
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Abstract

Although domestic violence is understood as including more than acts of physical violence, research to document many of the specific types of coercion that may be involved has been limited until recently. This report presents findings from two surveys conducted with callers to the National Domestic Violence Hotline that asked briefly about their experience with different forms of mental health and substance use coercion used by their abusive partners. Respondents were adult women who had experienced domestic violence (DV), were not in immediate crisis, had completed the service portion of their hotline call, agreed to participate after hotline staff explained the surveys' topics, and were assured that survey participation was voluntary and anonymous. Each survey—one on mental health coercion and one on substance use coercion—was conducted by hotline staff over a period of six weeks and involved over 2,500 participants. Results showed that experiencing these two types of coercion were common among hotline callers: 89% had experienced at least one of the three types of mental health coercion asked about, and 43% had experienced at least one of the three types of substance use coercion. Most of the survivors who reported any type, reported more than one. In addition, most survivors who reported their abusive partners had actively contributed to mental health difficulties or their use of substances also said their partners threatened to use the difficulties or substance use against them with important authorities, such as legal or child custody professionals, to prevent them from obtaining custody or other things that they wanted or needed. Detailed analysis of results also shows that the more types of coercion survivors experienced, the more likely they were to seek help. The report reveals the importance of knowing about the prevalence of these experiences among survivors. It also discusses the implications for health, mental health, substance abuse, legal, and advocacy practice and offers guidance for integrating questions and brief interventions into advocacy and clinical work.

Introduction

Over the past 40 years, advocates and researchers have engaged in a wide variety of efforts to understand, respond to, and prevent domestic violence (DV). From the beginning, the DV field has understood DV as a pattern of power and control that extends beyond acts of physical and sexual violence. Intimidation, manipulation, threats, undermining, and other tactics used to instill fear and sustain domination were recognized as central elements (see, e.g., Fleming, 1979; Schechter, 1982). For example, it is well documented that use of violence or its threat to reinforce an ongoing dynamic of domination and intimidation can have profound effects—it is that pervasive, all-encompassing dynamic that survivors often say is especially devastating (Stark, 2007). Over the years, researchers have documented numerous types and tactics of coercive control and violence, including psychological abuse (e.g., Tolman, 1989), economic abuse (e.g., Adams, Sullivan, Bybee & Greeson, 2008), and reproductive coercion (e.g., Miller et al., 2010). Qualitative studies have described coercion by abusive partners that extends to forced illegal behavior (e.g., Richie, 1996).

Recent national surveys have also begun to incorporate questions about psychological aggression when they measure experiences of violence. The National Intimate Partner and Sexual Violence Survey (NISVS) (Black et al., 2011) asked questions about both "expressive aggression," such as name calling, humiliating, or insulting, and "coercive control," such as monitoring and threatening. In some studies of women who have experienced both physical violence and other control tactics, women reported that the emotional abuse had a more severe and long-lasting effect than the physical abuse (e.g., Follingstad, Rutledge, Berg, Hause & Polek, 1990; Pico-Alfonso et al., 2005, 2006).

Similarly, there is now a fairly large body of research demonstrating that survivors of DV are at greater risk for experiencing a range of mental health conditions (such as depression, posttraumatic stress disorder [PTSD], suicidality), as well as substance use disorders (Trevillon et al., 2012; Nathanson et al., 2012; Dillon et al., 2013). Research has also documented high rates of DV among women seen in mental health and substance abuse treatment settings (Cohen et al., 2003; Schneider et al., 2009; Chang et al., 2011; Oram et al., 2103). Moreover, some DV advocates and survivors have voiced concerns about the ways mental health and substance use issues are used *against* survivors of DV and sexual assault, not only by abusers but also by the systems in which women seek help (e.g., batterers using mental health and substance use issues to control their partners; undermine them in custody battles; and discredit them with friends, family, child protective services, immigration authorities, and the courts) (Warshaw, Brashler & Gil, 2009). While there are now numerous studies examining the mental health impact of DV, in general they have been designed to investigate

(1) prevalence of specific psychiatric diagnoses among survivors of DV, (2) other effects of DV for which there are validated measurements (e.g., self-esteem), (3) the co-occurrence and/or timing of DV and substance use/abuse, and (4) additional factors associated with these conditions (e.g., socioeconomic status, other traumatic experiences).

None of this research, however, specifically examines the role of coercive control in the development and exacerbation of these conditions or the way DV perpetrators use mental health and substance abuse diagnoses and treatment as a means to further control their partners. In fact, although anecdotal evidence abounds, and sensationalized media accounts have occasionally captured public attention, very little research has directly addressed overt mental health and substance use coercion in the context of DV. The two brief pilot studies described in this report were designed to begin to bridge that gap.

Methods

The first pilot study investigated the use of mental health coercion among people who called the National Domestic Violence Hotline (NDVH) and identified as a victim/survivor of DV. Questions were developed with input from the National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH). NDVH has experience with administering voluntary surveys with callers after requested services have been provided. These "focus surveys" investigate specific issues and are limited to a maximum of five questions. The questions were reviewed by hotline advocates to ensure the language was clear and would be understood by callers. The survey introduction and questions were translated into Spanish by hotline advocates who handle calls with people who prefer to speak Spanish.

Training on the survey protocol, the questions, the rationale for the survey, and ways to respond to any issues that might be raised by participants as a result of the survey was provided to three shifts of NDVH staff who would be asking the questions. Supplementary resources for referrals related to mental health concerns were provided to NDVH staff following the training. The survey was administered over a period of six weeks (February 1, 2012 to March 14, 2012) to callers who (1) identified as a victim/survivor of DV, (2) were not in immediate crisis, and (3) agreed to participate after the survey topic was described and confidentiality was assured.[1]

[1] The introductory script was as follows: "People who experience violence by their partner can often feel like they are going 'crazy' or 'losing their mind' or just lose hope and feel down all the time. Sometimes their partners may cause these feelings deliberately, or use these feelings as a way of trying to control them. We are conducting a brief voluntary survey of

A similar procedure was followed for the pilot survey on substance use coercion. This survey was administered during the six-week period from April 23, 2012 to June 4, 2012.

Results

Mental Health Coercion Survey

During the survey period, 9,343 callers identified as having experienced DV and 2,875 (30.8%) were asked to participate in the survey. 95.1% of the survey respondents were female and 4.9% were male. Because respondents were so disproportionately female, meaningful gender comparisons could not be completed; the responses from male survivors are not included in this report. Of the 8,919 female callers who identified as having experienced DV, 2,733 were asked to participate in the survey, and 2,546 (93.2%) agreed to do so. The Mental Health Coercion Survey is comprised of five questions: four standard questions and one follow-up question. Throughout the course of the survey, respondents could choose to not answer any question. 8.3% of survey respondents declined to answer Question One, with between 8.6% and 9.3% of callers choosing not to answer Questions Two through Four. Callers who responded "yes" to Question Four were asked a follow-up question (Question Five); 1.7% of those callers chose not to answer Question Five.

Participant Demographics

Survey respondents were asked to provide other demographic information, including age and race or ethnicity. 2,525 respondents provided information on their age. This information is included in the table below.

Age of Respondents						
18-24	25-35	36-45	46-54	55-64	65 +	*Total*
369 *(14.6%)*	950 *(37.6%)*	656 *(26.0%)*	375 *(14.9%)*	148 *(5.9%)*	27 *(1.1%)*	2,525

2,487 survey respondents described their race or ethnicity, and this information is included in the table that follows.

Race/Ethnicity of Respondents	
African American	483 *(19.4%)*
Asian American (East/Southeast/South)	69 *(2.8%)*
Caucasian	1,335 *(53.7%)*
Hispanic/Latina	467 *(18.8%)*
Native American/Alaska Native	28 *(1.1%)*
Native Hawaiian/Pacific Islander	7 *(0.3%)*
Middle Eastern/Arab/Iranian American	15 *(0.6%)*
More than one race/ethnicity	83 *(3.3%)*
Total	2,487

Survey Question Responses

Responses to each survey question are as follows:

- **Question One**: Has your partner or ex-partner ever called you "crazy" or accused you of being "crazy"?
    - 2,149 callers (85.7%) answered yes to this question.
- **Question Two:** Has your partner or ex-partner ever threatened to report to authorities that you are "crazy" to keep you from getting something you want or need (e.g., custody of children, medication, protective order)?
    - 1,197 callers (50.2%) answered yes to this question.
- **Question Three:** Do you think your partner or ex-partner has ever deliberately done things to make you feel like you are going crazy or losing your mind?
    - 1,740 callers (73.8%) answered yes to this question.

- **Question Four:** In the last few years, have you ever gone to see someone like a counselor or social worker or therapist or doctor to get help with feeling upset or depressed?
    - 1,231 callers (53.2%) answered yes to this question.
- **Question Five (asked if "yes" to Question Four):** Has your partner or ex-partner ever tried to prevent or discourage you from getting that help or taking medication you were prescribed for your feelings?
    - 560 callers (49.6%) answered yes to this question.

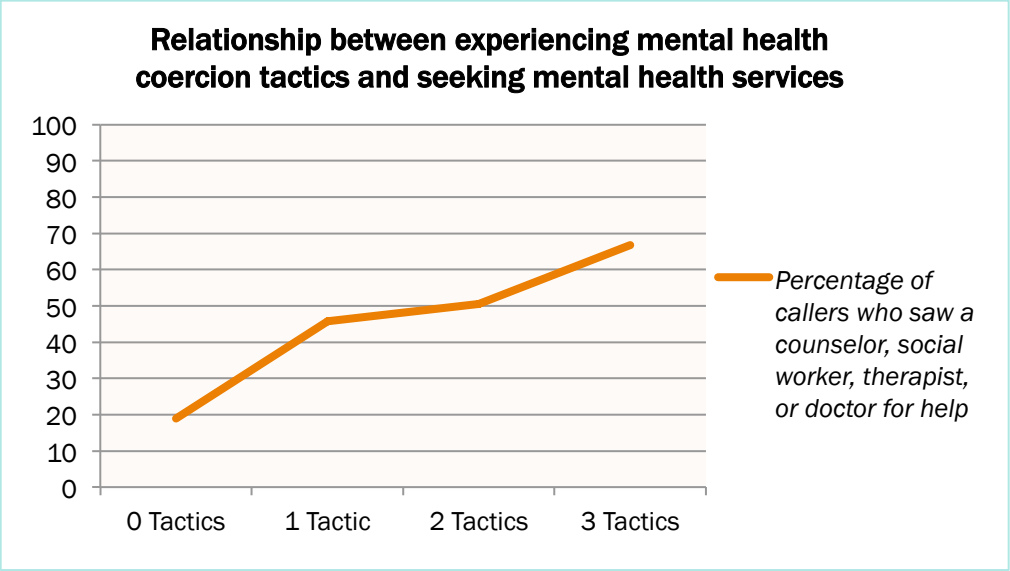
Number of Mental Health Coercion Tactics Used

The number of mental health coercion tactics reported by callers was calculated by summing the "yes" responses for Questions One, Two, and Three. Question Four was omitted from this analysis as it pertains to help-seeking and is not itself a mental health coercion tactic, and Question Five was omitted because it was only asked if callers said yes to Question Four. Respondents reported experiencing an average of two mental health coercion tactics. Overall, 89% of respondents reported experiencing at least one type of mental health coercion, 73% experienced at least two types, and 40% experienced all three. The number of mental health coercion tactics that callers reported experiencing is shown in the following table:

Number of Tactics Reported	0	1	2	3	*Total*
	274 *(10.9%)*	393 *(15.7%)*	839 *(33.4%)*	1005 *(40.0%)*	2511

To better understand the relationship between experiencing mental health coercion tactics and receiving mental health services, the number of tactics experienced was compared to responses to Question Four (*In the last few years, have you ever gone to see someone like a counselor or social worker or therapist or doctor to get help with feeling upset or depressed?*). The results are shown in the following table and are illustrated in the accompanying graph:

		Number of Tactics Used				
		0	1	2	3	*Total*
Saw a counselor, social worker, therapist, or doctor for help	Yes	50 *(19.8%)*	150 *(45.5%)*	391 *(50.5%)*	640 *(66.7%)*	1231
	No	203 *(80.2%)*	180 *(54.5%)*	383 *(49.5%)*	319 *(33.3%)*	1085
	Total	253	330	774	959	2316



These results show a direct relationship between the number of coercion tactics and seeking help for depression or feeling upset: the more mental health coercion tactics she experienced, the more likely the caller was to seek help from a professional.

Results by Age and Race/Ethnicity

For the first three questions, survey respondents ages 18-24 were significantly less likely to report having had the particular experience. Respondents aged 18-24 also had the highest rates of reporting having experienced zero mental health coercion tactics (15.1%). Respondents aged 36-45 and 55-64 reported the highest rates of experiencing all three tactics (44.6% and 43.7%, respectively). There were also relationships between age and individual items, as follows:

- For **Question 1** (Has your partner or ex-partner ever called you "crazy" or accused you of being "crazy"?), callers aged 36–45 had the highest rates of reporting having experienced this tactic (89.3%).
- For **Question 2** (Has your partner or ex-partner ever threatened to report to authorities that you are "crazy" to keep you from getting something you want or need [e.g., custody of children, medication, protective order]?), callers aged 36–45 had the highest rates of reporting having experienced this tactic (53.8%).
- For **Question 3** (Do you think your partner or ex-partner has ever deliberately done things to make you feel like you are going crazy or losing your mind?), callers aged 55–64 had the highest rates of reporting having experienced this tactic (82.5%).

- For **Question 4** (In the last few years, have you ever gone to see someone like a counselor or social worker or therapist or doctor to get help with feeling upset or depressed?), callers aged 65 and older had the highest rates of reporting having done this (69.6%).
- For **Question 5** (Has your partner or ex-partner ever tried to prevent or discourage you from getting that help or taking medication you were prescribed for your feelings?), callers aged 65 or older had the highest rates of reporting having experienced this tactic (53.8%).

In addition, analyses were conducted to learn more about the relationship between respondents' race or ethnicity and experience of mental health coercion tactics. Respondents who identified as being Asian American had the highest rates of reporting having experienced zero mental health coercion tactics (16.7%). Respondents who identified as being Native American or Alaska Native had the highest rates of reporting having experienced all three mental health coercion tactics (51.9%). However, there are large differences in the numbers of callers from each racial or ethnic group: 1,335 callers identified as being Caucasian, 69 identified as Asian American, and 28 callers identified as being Native American or Alaska Native. Because of these large differences, the preceding results should be viewed with caution.

Relationships Between Responses

Analyses were conducted to better understand the relationships between the types of mental health coercion tactics that callers reported experiencing. Highlights include the following:

- **57.6%** of respondents who reported that their partner or ex-partner called them "crazy" or accused them of being "crazy" also reported that their partner or ex-partner threatened to report to the authorities that they were "crazy" to keep them from getting something that they wanted or needed.
- **82.1%** of respondents who reported that their partner or ex-partner called them "crazy" or accused them of being "crazy" also reported that their partner or ex-partner had done things to make them feel that they were going "crazy" or losing their mind.
- **88.6%** of respondents who reported that their partner or ex-partner threatened to report to authorities that they were "crazy" to keep them from getting something that they wanted or needed also reported that their partner or ex-partner had done things to make them feel that they were going "crazy" or losing their mind.
- **96.2%** of respondents who reported that their partner or ex-partner discouraged or prevented them from getting help or taking medications prescribed for their feelings also

reported that their partner or ex-partner called them "crazy" or accused them of being "crazy."

- **72.3%** of respondents who reported that their partner or ex-partner discouraged them from getting help or taking medications prescribed for their feelings also reported that their partner or ex-partner threatened to report to authorities that they were "crazy" to keep them from getting something that they wanted or needed.
- **84.3%** of respondents who have gone to a therapist, counselor, social worker, or doctor for help also reported that their partner or ex-partner had done things to make them feel that they were going "crazy" or losing their mind.

Other Information from Participants

In addition to collecting yes/no responses to each question, NDVH staff took notes on calls as appropriate. These notes provide additional information on survivors' experiences of mental health coercion. The following are common themes from these notes:

Callers reported that their abusive partners did the following:

- Told friends/family that they were unstable.
- Called them names.
- "Diagnosed" them (e.g., told the caller that she was bipolar).
- "Gas-lighted" them, twisting situations around to make them look or feel crazy.
- Did things to control their medications (e.g., withheld medications, stole medications, coerced them to take too much medication, called them an addict for taking medication).
- Attempted to convince police or doctors that they were mentally ill.
- Threatened to report their use of medication or mental health services to the court system in an attempt to influence custody cases.
- Used mental health diagnoses to make false allegations against their partners and get protective orders against them (which made it more difficult for survivors to obtain protections for themselves).

Substance Use Coercion Survey

During the survey period, 9,783 callers identified as having experienced DV and 3,380 (34.6%) were asked to participate in the survey. Similar to the rates found in the Mental Health Coercion Survey, 95.4% of the survey respondents were female and 4.6% were male. Because respondents were so disproportionately female, meaningful gender comparisons could not be completed and the responses from male survivors are not included in this report. Of the 9,359 female callers who identified as having experienced DV, 3,238 were asked to participate in the survey after its content was described and its voluntary nature was assured, and 3,056 (94.3%) agreed.[2] The Substance Use Coercion Survey was comprised of six questions: five standard questions and one follow-up question. Throughout the course of the survey, respondents could choose to not answer any question. 8.0% of survey respondents declined to answer Question One, and between 7.6% and 10.1% of respondents chose not to answer Questions Two through Five. Callers who answered "yes" to Question Five were asked a follow-up question (Question Six); 1.0% of callers chose not to answer Question Six.

Participant Demographics

Survey respondents were asked to provide other demographic information, including age and race or ethnicity. 3,018 respondents provided information on their age. This information is included in the table below.

Age of Respondents						
18-24	25-35	36-45	46-54	55-64	65 +	*Total*
422 *(14.0%)*	1,147 *(38.0%)*	831 *(27.5%)*	438 *(14.5%)*	150 *(5.0%)*	30 *(1.0%)*	3,018

[2] The introductory script: "Many times people who call our Hotline are dealing with a partner who is trying to maintain power and control in the relationship. Sometimes, they may use substance abuse as a way to maintain that power and control. In order to understand how this affects our callers we are doing a voluntary survey that, just like the rest of the information in this call, is anonymous and confidential. Do you mind if I ask you a few questions about some things that may have happened in your relationship?"

3,025 survey respondents described their race or ethnicity, and this information is included in the following table:

Race or Ethnicity of Respondents	
African American	676 *(22.3%)*
Asian American (East/Southeast/South)	69 *(2.3%)*
Caucasian	1,484 *(49.1%)*
Hispanic/Latina	627 *(20.7%)*
Native American/Alaska Native	33 *(1.1%)*
Native Hawaiian/Pacific Islander	7 *(0.2%)*
Middle Eastern/Arab/Iranian American	18 *(0.6%)*
More than one race/ethnicity	111 *(3.7%)*
Total	3,025

Survey Question Responses

Responses to each survey question are as follows:

- **Question One:** Has your partner or ex-partner ever pressured or forced you to use alcohol or other drugs, or made you use more than you wanted?
    - 801 callers (27.0%) answered yes to this question.
- **Question Two:** Has your partner or ex-partner ever threatened to report your alcohol or other drug use to anyone in authority to keep you from getting something you want or need (e.g., custody of children, a job, benefits, or a protective order)?
    - 964 callers (37.5%) answered yes to this question.
- **Question Three:** Have you ever been afraid to call the police for help because your partner or ex-partner said they wouldn't believe you because you were using, or you would be arrested for being under the influence of alcohol or other drugs?
    - 527 callers (24.4%) answered yes to this question.

- **Question Four:** Have you ever used alcohol or other drugs as a way to reduce the pain of your partner or ex-partner's abuse?
    - 545 (26.0%) answered yes to this question.
- **Question Five:** In the last few years, have you ever tried to get help for your use of alcohol or other drugs?
    - 306 callers (15.2%) answered yes to this question.
- **Question Six (asked if "yes" to Question Five:** Has your partner or ex-partner ever tried to prevent or discourage you from getting that help?
    - 181 callers (60.1%) answered yes to this question.

Number of Substance Use Coercion Tactics Used

The number of substance use coercion tactics reported by callers was calculated by summing the "yes" responses for Questions One, Two, and Three. Questions Four and Five were omitted from this analysis as they are not substance use coercion tactics. Question Six was omitted from this analysis because it was only asked if respondents said yes to Question Five. The overall number of substance use coercion tactics that callers reported experiencing is shown in the following table:

Number of Tactics Reported	0	1	2	3	*Total*
	1,704 (57.1%)	560 (18.8%)	425 (14.2%)	294 (9.9%)	2,983

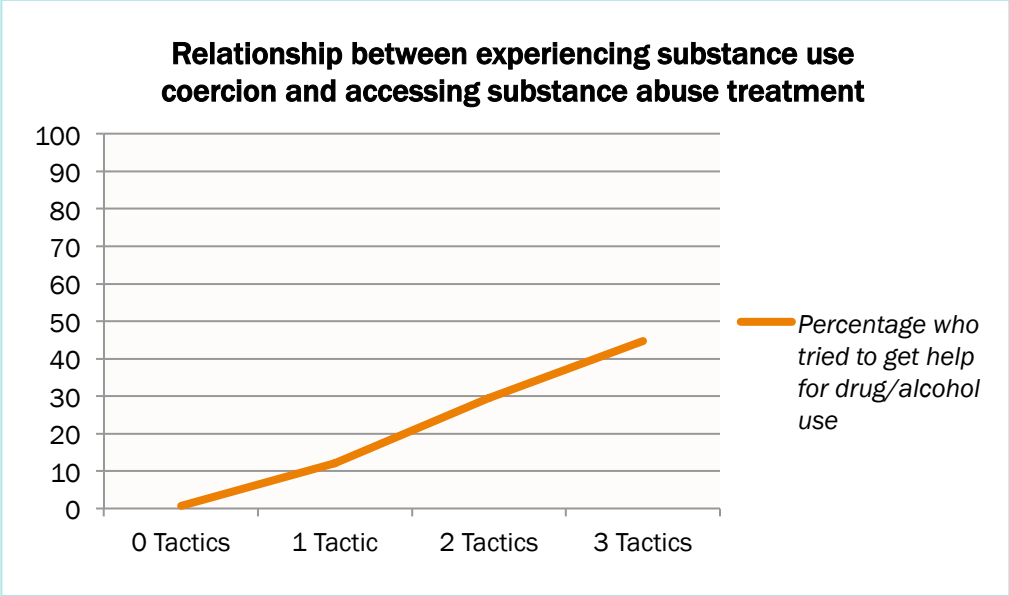
Although a majority of callers indicated they had not experienced any substance use coercion tactics, most of those who did reported more than one.

To better understand the relationship between experiencing substance use coercion tactics and receiving treatment for drug or alcohol use, the number of tactics experienced was compared to responses to Question Five (*In the last few years, have you ever tried to get help for your use of alcohol or other drugs?*).

The results are shown in the following table and illustrated in the accompanying graph:

		Number of Tactics Used				
		0	1	2	3	*Total*
Tried to get help for your use of alcohol or other drugs	Yes	6 (0.7%)	58 (12.1%)	115 (29.5%)	127 (44.7%)	306
	No	855 (99.3%)	421 (87.9%)	275 (70.5%)	157 (55.3%)	1,708
	Total	861	479	390	284	2,014

Again, the relationship between the number of substance use coercion tactics and seeking help for use of alcohol or other drugs is direct: the more of these coercion tactics she experienced, the more likely the caller was to seek help.



Results by Age and Race/Ethnicity

For all but one of the questions, survey respondents ages 55 or older were significantly less likely to report having had the particular experience. Respondents aged 36-45 had the highest rates of experiencing all three coercion tactics (10.4%).

- For **Question 1** (Has your partner or ex-partner ever pressured or forced you to use alcohol or other drugs, or made you use more than you wanted?), callers aged 36–45 had the highest rates of reporting having experienced this tactic (28.1%).

- For **Question 2** (Has your partner or ex-partner ever threatened to report your alcohol or other drug use to anyone in authority to keep you from getting something you want or need [e.g., custody of children, a job, benefits, or a protective order]?), callers aged 18–24 had the highest rates of reporting having experienced this tactic (41.1%).
- For **Question 3** (Have you ever been afraid to call the police for help because your partner said they wouldn't believe you because you were using, or you would be arrested for being under the influence of alcohol or other drugs?), callers aged 36–45 had the highest rates of reporting having experienced this tactic (26.1%).
- For **Question 4** (Have you ever used alcohol or other drugs as a way to reduce the pain of your partner or ex-partner's abuse?), callers aged 18–24 had the highest rates of reporting having done this (27.6%).
- For **Question 5** (In the last few years, have you ever tried to get help for your use of alcohol or other drugs?), callers aged 65 and older had the highest rates of reporting having done this (18.8%).
- For **Question 6** (Has your partner or ex-partner ever tried to prevent or discourage you from getting that help?), callers aged 65 and older had the highest rates of reporting having experienced this tactic (66.7%).

In addition, analyses were conducted to learn more about any significant relationships between respondents' race or ethnicity and experience of substance use coercion tactics. Respondents who identified as being Asian American had the highest rates of reporting having experienced zero substance use coercion tactics (75.4%). Respondents who identified as being Native American or Alaska Native had the highest rates of reporting having experienced all three substance use coercion tactics (21.2%). However, there are large differences in the numbers of callers from each racial or ethnic group: 1,388 callers identified as being Caucasian, 65 callers identified as Asian American, and 33 identified as being Native American or Alaska Native. Because of these large differences, the preceding results should be viewed with caution.

Relationships Between Responses

Analyses were conducted to better understand the relationships between the types of substance use coercion tactics that callers reported experiencing. Highlights include the following:

- **66.5%** of callers who reported that their partner or ex-partner had forced or pressured them to

use alcohol or other drugs, or made them use more than they wanted, also reported that their partner or ex-partner had threatened to report their alcohol or other drug use to authorities to keep them from getting something they wanted or needed.

- **47.7%** of callers who reported that their partner or ex-partner had forced or pressured them to use alcohol or other drugs, or made them use more than they wanted, also reported that they have been afraid to call the police for help because their partner or ex-partner said they wouldn't believe them because they were using, or that they would be arrested for being under the influence of alcohol or other drugs.
- **82.0%** of callers who reported that they have been afraid to call the police for help because their partner or ex-partner said they wouldn't believe them because they were using, or that they would be arrested for being under the influence of alcohol or other drugs also reported that their partner or ex-partner had threatened to report their alcohol or other drug use to authorities to keep them from getting something they wanted or needed.
- **69.7%** of callers who reported that they have used alcohol or other drugs to reduce the pain of their partner or ex-partner's abuse also reported that they have been afraid to call the police for help because their partner or ex-partner said they wouldn't believe them because they were using, or that they would be arrested for being under the influence of alcohol or other drugs.
- **60.1%** of callers who reported having tried to get help for alcohol or other drug use in the last few years also reported that their partner or ex-partner prevented or discouraged them from getting that help.
- **92.4%** of callers who reported having tried to get help for alcohol or other drug use in the last few years also reported that their partner or ex-partner had threatened to report their alcohol or other drug use to authorities to keep them from getting something they wanted or needed.
- **94.0%** of callers who reported that their partner or ex-partner had prevented or discouraged them from getting help for their alcohol or drug use also reported that their partner or ex-partner had threatened to report their alcohol or other drug use to authorities to keep them from getting something they wanted or needed.

Other Information from Participants

In addition to collecting yes/no responses to each question, NDVH staff took notes on calls as appropriate. These notes provide additional information on survivors' experiences of substance use coercion. The following are common themes from these notes:

Callers reported that their abusive partners did the following:

- Did not allow them to attend AA meetings or seek treatment for substance use concerns, either alone or at all.
- Withheld transportation or the financial resources needed for them to obtain treatment for substance use concerns.
- Kept substances in the home after they received treatment for substance use concerns.
- Pressured them to use drugs or alcohol and this was connected to coerced sex.
- Sexually assaulted them when they were passed out from drugs or alcohol.
- Used drugs or alcohol as a way to justify any type of sexually abusive behavior.

Discussion and Implications

These results from the two coercion surveys conducted with DV survivors who called the NDVH and were not in immediate crisis show clearly that mental health and substance use coercion is pervasive, even when it can only be measured with three questions.[3] This is especially true for mental health-related coercive tactics. Further, the majority of survivors who reported any coercion had experienced more than one of the tactics described. The more tactics they had experienced, the more likely they were to seek help for either mental health or substance use; when they did so, their partner tried to prevent or discourage them from doing so.

More detailed analysis of the relationships among specific tactics for each of the types of coercion helped to clarify these results. For example, the Mental Health Coercion Survey found that many survivors reported that their abusive partner called them "crazy" and did things deliberately to

[3] In fact, the rates are likely to underrepresent the prevalence of these types of coercion, because one might expect that survivors in crisis would experience coercion at higher rates. In addition, the potential inclusion of illegal substances in the substance use survey as well as stigma associated with substance use could have contributed to reluctance to acknowledge use—coerced or not—despite assurances of confidentiality. In addition, if there had been room to ask a comparable labeling question, i.e., "Did your partner or ex-partner ever accuse you of being an addict or put you down you for using," in the substance use coercion survey, the results may have been more similar.

make them feel "crazy," and also threatened to undermine their credibility with authorities and discouraged or prevented them from getting help. The Substance Use Coercion Survey found that many survivors reported that their abusive partners used force or pressure to get them to use substances and also threatened to undermine them with authorities by disclosing their substance use. Survivors who were afraid to call police for help because their partner said they would not be believed due to their substance use also reported that they had been threatened with having their substance use reported to authorities to prevent them from getting something they wanted or needed. These tactics—especially in combination—clearly limit survivors' options, choices, and ability to get help.

Implications for the Health, Mental Health, and Substance Abuse Fields

While the health, mental health, and substance abuse fields have increasingly begun to recognize the prevalence and impact of lifetime trauma among the people they serve, recognition of the role that ongoing coercive control by an abusive partner plays in the development of mental health and substance use symptoms and disorders is uncommon. For example, although many trauma-informed practitioners are aware that use of alcohol and other drugs may be a form of self-medication or a survival strategy for coping with the traumatic effects of abuse, they are less often aware of the role an abusive partner may be playing in coercing his or her partner to use and/or in actively sabotaging recovery. Similarly, while experiencing abuse by an intimate partner is associated with a range of traumatic effects, including depression, anxiety, PTSD, and suicidality, practitioners may not be aware of the role an abusive partner may be playing in actively inducing mental health symptoms or the ways that experiencing a mental health or substance abuse condition puts women at greater risk for being controlled by an intimate partner. While experiencing mental health or substance abuse-related symptoms can affect one's ability to mobilize resources or think strategically, it is

Responding to Mental Health and Substance Use Coercion: Implications for Clinical Practice

- → Ask routinely
- → Validate perceptions, acknowledge impact, express concern
- → Collaborate to develop safe strategies for addressing coercive behaviors and their effects
- → Document in ways that link symptoms and ability to participate in treatment to the abuse; document efforts to protect and care for children
- → Provide linkages or "warm referrals" to community DV resources
- → Incorporate into long-term treatment considerations
- → Recognize the importance of ensuring that services are both DV- and trauma-informed

often the combination of trauma-related symptoms, abuser-induced disability, and stigma associated with mental health and substance use disorders that allows abusers to use these issues against their partners successfully. For example, abusers may justify their use of violence by saying their partner was "out of control" and needed to be restrained or they may be asked to provide collateral information during an ER visit and lie outright about what happened. This is particularly insidious when the abusive party appears to be "more stable" than the person they have been abusing for years, or if their partner has limited English proficiency and/or cannot safely speak for themselves.

While experiencing mental health or substance abuse-related symptoms can affect one's ability to mobilize resources or think strategically, it is often the combination of trauma-related symptoms, abuser-induced disability, and stigma associated with mental health and substance use disorders that allows abusers to use these issues against their partners successfully.

While rates of current and past abuse by an intimate partner are high among women seen in health, mental health, and substance abuse settings, many are not asked about current DV or more specifically about their partners' efforts to undermine their sanity or sobriety and parenting, to control medication and treatment, or to sabotage their recovery and access to resources and support (Edmund and Bland, 2008; Nyame et al., 2013; Kunins et al., 2007). Talking with survivors about the ways their partner may be attempting to use their substance use or mental health condition against them, particularly around issues of custody and credibility in court, can create opportunities to offer perspective, validate perceptions, attend to safety, and develop both short-term strategies (e.g., ensuring access to treatment and medication, limiting the role of an abusive partner in treatment and decision-making, ensuring confidentiality with regard to clinical information and billing) and longer-term approaches for addressing these concerns.

The findings from these two surveys underscore the importance of incorporating questions about mental health and substance use coercion into routine mental health and substance abuse assessments, addressing these issues as part of brief counseling interventions and more formal treatment, documenting the relationship between a survivor's mental health or substance abuse symptoms and ability to participate in treatment and their partner's abusive behaviors, and providing linkages and referrals to DV advocacy supports in the community or clinical setting.[4]

[4] See forthcoming NCDVTMH Guidelines for Screening, Assessment and Brief Counseling for Mental Health and Substance Use Coercion in Primary Health Care Settings, at http://www.nationalcenterdvtraumamh.org/publications-products/.

Implications for Law Enforcement, Prosecutors, Attorneys, and Judges

Over time, judges, prosecutors, attorneys, and law enforcement professionals have become increasingly aware of the dynamics of DV. Yet, despite this awareness, stigma associated with substance abuse and mental illness may impact the perceptions of law enforcement and legal professionals, a situation that abusers too often use to their advantage. Furthermore, while there has been an increase in awareness that substance abuse or mental health symptoms may be associated with past trauma, awareness of the kinds of coercive tactics documented in this survey—and their impact on survivors and legal cases involving DV—is likely very low.

Among the findings that are potentially most relevant for law enforcement and legal professionals, these studies illuminate how abusers actively compromise their partners' mental health and sobriety, force or pressure their partners into using alcohol or other drugs and/or force their partners into using more than they wanted, and also then intimidate their partners with threats related to their mental health and substance use. These surveys document that abusers interfere with their partners' ability to get help, such as by telling their partners that they will not be believed or would themselves be arrested if they called the police or sought other assistance. Survivors also were told by their abusers that they were "crazy," that no one would take them seriously, and that they would never be able to obtain custody if they tried to leave.

With regard to the criminal justice system, these recognitions could potentially help law enforcement establish probable cause. They may also help prosecutors to build legal cases, and they can help judges have better insight into cases where mental health or substance use coercion plays a role. For law enforcement professionals and prosecutors, recognizing the attempts of an abuser to discredit a partner based on mental health or substance related concerns or to justify his or her behavior on that basis is critical to victim safety. Being able to raise these issues may also be essential in the context of criminal as well as civil protection orders.

Awareness of how these issues play out in DV custody cases is critical for attorneys and judges as well. For example, abusers may accuse their partners of being unable to parent due to their mental health diagnosis or history or use of substances.[5] Because of the stigma and fear attached to mental illness and substance use, this can be a powerful accusation. Family law judges should always be skeptical of testimony by one litigant that relies on overly broad generalizations and simply equates

[5] For more insight into the use of mental health stigma against survivors in custody cases and how lawyers can respond, see Wolf Markham, D. (2003). Mental illness and domestic violence: Implications for family law litigation. *Journal of Poverty Law & Policy*, 23-35. Available at http://www.povertylaw.org/clearinghouse-review/issues/2003/20030515/500941; and Seighman, M.M., Sussman, E., & Trujillo, O. (2011). Representing domestic violence survivors who are experiencing trauma and other mental health challenges: A handbook for attorneys (NCDVTMH publication). Available at http://www.nationalcenterdvtraumamh.org/publications-products/attorneys-handbook/.

Responding to Mental Health and Substance Use Coercion: Implications for DV Programs

- → Provide information about mental health and substance use coercion that offers perspective and helps reduce isolation and stigma
- → Incorporate into discussions about program accessibility, safety planning, risk assessment, support group topics, and legal advocacy
- → Provide outreach, education, and advocacy with community providers and systems

the other litigant's mental health diagnosis with an inability to parent. Instead, a case-by-case assessment of the impact of the mental health condition on the best interest of the child is required, and custody lawyers should argue for this approach.[6] Particularly in cases where the accused parent has in fact been the primary parent prior to litigation without prior objection from the accusing parent, such accusations should raise a red flag, alerting judges of the possibility that such stated concerns may not be genuine but rather may be part of a pattern of coercive control. As always, identifying the presence of DV and its impact on the protective parent and the children is critical to determining the best interest of the children in custody cases. Assessing for the presence and impact of mental health and substance use coercion is one critical part of this analysis.

Implications for Survivors and Advocates

Hotline advocates documented numerous comments made by the callers who participated in these surveys about how these questions spoke directly to their experience ("This just hit the nail on the head.") and how important and validating it was to be asked. Many said that no one had ever talked with them about mental health or substance use coercion being part of DV and many said that they had never talked about these experiences with others. Having another person recognize these tactics and their impact is both empowering and potentially life saving, particularly if a survivor is living with or involved with an abusive partner who is able to convince other people they are not credible and is able to convince the survivor that they won't be believed, that they are the one with the problem and deserve to be abused, or that they are unfit as a parent.

Talking with survivors about mental health and substance use coercion—including how mental health symptoms and substance abuse often stem not only from the traumatic effects of abuse but

[6] See Geva, A.S. (2012). Judicial determination of child custody when a parent is mentally ill: A little bit of law, a little bit of pop psychology, and a little bit of common sense. *U.C. Davis Journal of Juvenile Law & Policy*, 16(1) (arguing that there is a "nexus" requirement).

also from deliberate behaviors on the part of an abusive partner—can provide perspective and helps to reduce isolation and stigma. This in turn can reduce an abusive partner's ability to successfully use these issues as tactics of control (see NCDVTMH's Mental Health and Substance Abuse Coercion Tipsheet).[7] It can be reassuring and helpful for advocates to routinely acknowledge how common the experience of mental health and substance use coercion is, and how many options are available. It also helps to reassure a survivor experiencing psychiatric symptoms or a substance use disorder that, just as a survivor is not responsible for the harm another human being has done, a survivor is also not responsible for the biopsychosocial factors that led to the development of a psychiatric disability or substance use disorder (Bland, 2011). Strategies for addressing mental health and substance use coercion can be developed with survivors as part of safety planning, individual counseling and group discussions, and activities that support survivors' parenting and well-being. Efforts to respond to mental health and substance use coercion can also be incorporated into education and advocacy with the health, mental health, substance abuse, and legal systems.

Summary

Mental health and substance use coercion are highly prevalent forms of abuse that are critical to keep in mind when working with survivors of domestic violence. They include

- → efforts to undermine a partner's sanity and sobriety;
- → efforts to induce disability and dependency;
- → efforts to control a partner's access to treatment and other services;
- → efforts to control a partner's treatment, itself, including medications;
- → efforts to undermine a partner's recovery;
- → efforts to undermine a partner's ability to maintain custody of her children; and
- → efforts to undermine a partner with family, friends, and the systems where they seek help and to prevent them from accessing resources, support, and protection.

Stigma, in turn, plays a key role in allowing abusive partners to employ these tactics so successfully. Recognizing and addressing these issues is essential to the safety and well-being of survivors and their children and has important implications for the health, mental health, substance abuse, legal, child welfare, immigration, public benefits, and DV advocacy systems.

Conclusion

These two studies offer a first compelling look at mental health and substance use coercion as common, but often overlooked components of DV. While advocates and survivors have long recognized these issues, this is the first study focused on documenting the extent and scale of this problem. The

[7] Available at http://nationalcenterdvtraumamh.org/wp-content/uploads/2012/01/Mental-Health-and-Substance-Abuse-Coercion.pdf.

constellation of abusive behaviors highlighted by this report—deliberately doing things to undermine a partner's sanity, sobriety, and recovery; controlling a partner's access to treatment and support; and then using the success of these tactics to actively undermine a partner's credibility with the people and systems from whom they might seek help—provides an additional disturbing layer of insight into the coercive control that is central to our understanding of DV. Equally disturbing is the role that stigma associated with substance abuse and mental health disorders plays in facilitating the ability of DV perpetrators to successfully employ this type of abuse.

In sum, these findings have important implications for survivors and their children and for all of the systems with which they interact, including the mental health, substance abuse, healthcare, legal, and DV service systems. For health, mental health, and substance abuse treatment providers, routinely asking about mental health and substance use coercion, incorporating awareness of them into brief counseling and longer-term services, discussing the risks of involving a potentially abusive partner in treatment or decision-making, documenting the abuse, and linking with DV advocacy resources is critical. For law enforcement and legal professionals, recognizing the role mental health and substance use coercion may be playing in a survivor's legal case and not allowing abusers to rely on stigma or overly broad generalizations in protection order hearings or custody battles can be crucial to supporting the safety and well-being of both survivors and children. For DV advocates, incorporating awareness of mental health and substance use coercion into services, safety planning, and community advocacy has the potential to decrease the ability of abusers to use these issues against their partners. And for funders and policymakers, recognizing the need to support more coordinated efforts to address these complex issues will be key to reducing this form of abuse and its overall impact on survivors and their children.

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