WHEN CRISES COLLIDE:

EXPLORING THE IMPLICATIONS WHEN INTERPERSONAL VIOLENCE INTERSECTS WITH PERSISTENT POVERTY, MENTAL HEALTH ISSUES AND SUBSTANCE USE

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HISTORICAL VIEW OF IPV AND OTHER ISSUES

- ❖ Initial framing of anti-domestic violence movement:
  - IPV knows no class boundaries.
  - Addressing IPV is of paramount importance.

- ❖ Led to great success

- ❖ Unintended negative consequences

CO-OCCURRENCE OF IPV , POVERTY, MENTAL HEALTH CHALLENGES AND SUBSTANCE USE

Each of these, and certainly in combination, may increase a person's vulnerability to abuse, constrain options for change, and be exacerbated by violence.
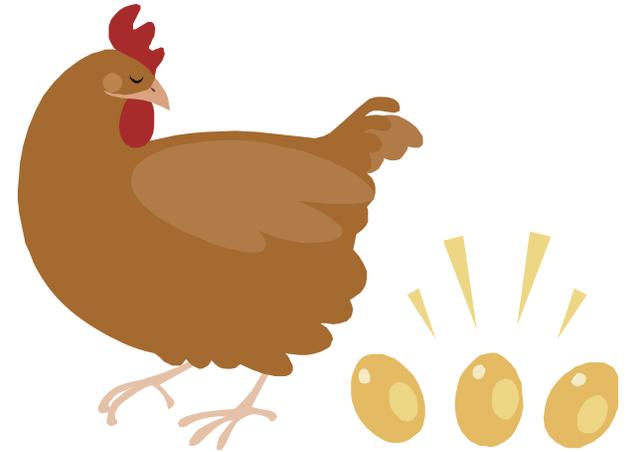
Each of these, and certainly in combination, may increase a person's likelihood to abuse, and exacerbate violence.

POVERTY: A SNAPSHOT

❖ One in eight Americans lives in poverty.

❖ One in 20 Americans is poor for 10 or more years in any 13 year period.

❖ Nearly 1/5 of children are poor; 43% of children in female-headed households are poor.

❖ Minorities are far more likely to be poor; immigrants are poorer than non-immigrants; women are poorer than men.

4

POVERTY, IPV, MENTAL HEALTH, & SUBSTANCE USE

Household income level is one of the most significant correlates of IPV. (e.g. Cunradi, Caetano, & Schafer, 2002)

❖ 30%-74% of women reliant on TANF have experienced IPV. (Goodman, Smyth, Singer, & Borges, 2009)

❖ The majority of homeless women have been assaulted by their partners. (Browne & Bassuk, 1997); IPV is a direct cause of homelessness of 22% - 57%.

Substance abuse is highly correlated with IPV victimization…

❖ $\pm$ 60% of women in substance abuse treatment are survivors of violence. (studies cited in Zweig, Schlichter, & Burt, 2002)

❖ 42% of women receiving IPV services also face substance abuse . (Bennett & Lawson, 1994)

…and with perpetration. (e.g., Lipsky, Caetano, Field, & Larkin, 2005)

5

POVERTY, IPV, MENTAL HEALTH, & SUBSTANCE USE

Mental illness and IPV are highly correlated:

- $\pm$ 40% - 63% of women with SMI are survivors of IPV.
- 87% of homeless women with SMI have been physically abused. (Goodman, Dutton, & Harris, 1995)
- IPV survivors experience greater rates of depression, PTSD, suicidality and other distress.

Psychological abuse is even more heavily correlated with poor physical and mental health outcomes than is physical abuse alone. (Coker et al, 2002)

And, of course, poverty, substance use, and mental health challenges are inextricably connected as well.

- Women who are poor suffer depression, PTSD, addiction and anxiety at rates significantly higher than in the general population.

6

BUT AREN'T THESE COMPLETELY DIFFERENT "CONDITIONS"?

Yes, as long as

→ poverty is framed entirely as a resource issue,

→ IPV is framed as a relationship issue,

→ addiction is framed as a self-control or medical issue, and

→ mental health is framed as a psychological/internal issue.

But this framing is incomplete.

THE PERNICIOUS THREE:
STRESS, POWERLESSNESS, AND ISOLATION

❖ Three negative effects shared by poverty, IPV, substance abuse and mental health challenges:
stress, powerlessness, and social isolation.

❖ These effects represent external realities that become internalized as subjective experiences that shape actions, attitudes, expectations and health.

STRESS

IPV produces chronic and acute stress

- ❖ Constant coercive control → chronic stress
- ❖ Violent episodes → acute stress

Poverty produces chronic and acute stress

- ❖ How to pay the bills, feed the family, etc. → chronic stress
- ❖ Evictions/homelessness, sudden loss of services, etc. → acute stress

Addiction and mental health challenges produce chronic and acute stress

- ❖ How to hide stigmatized conditions → chronic stress

Stress is linked to a range of adverse health outcomes

POWERLESSNESS

Occurs when:

❖ Stress becomes sufficiently intense and/or sustained.

❖ Repeated failed attempts to fix stressors lead to the (correct) belief that they cannot be overcome.

Powerlessness is associated with depression in IPV survivors and low-income women.

We (practitioners) may unintentionally reinforce powerlessness.

10

SOCIAL ISOLATION

IPV -> social isolation
- ❖ Abusers isolate
- ❖ Women "use up" support
- ❖ Family members distance out of fear

Poverty -> social isolation
- ❖ Contagion of stress; unwillingness to burden
- ❖ Absence of linking relationships

Addiction and mental health -> social isolation
- ❖ Shame
- ❖ Family members distance out of fear, hopelessness, "tough love"

Social Isolation ->
- ❖ Depression in low income women
- ❖ Anxiety, depression, and PTSD in IPV survivors
- ❖ Increase in substance use
- ❖ A range of negative health outcomes

COPING WITH STRESS IN THE FACE OF POWERLESSNESS AND ISOLATION

People cope.

Societal focus on external change as "progress" and signs of "coping" may be unrealistic and dangerous for a survivor.

Survival-focused coping as an alternative construct.

❖ Involves constant fine-tuned adjustments - "micro-control."
❖ This is a strength to be honored and built on.

THE ROLE OF CONNECTIONS

Social support, clearly the mitigator of social isolation, is also a key to coping with stress and powerlessness.

Social support may:

- ❖ Alter the perception of a stressor.

- ❖ Bolster a survivor's perception that she can successfully address her problems, with an understanding of constraints.

- ❖ Help to shift the situation itself.

IPV, poverty, substance abuse and mental health challenges compromise social support networks.

13

WHAT DOES THIS MEAN FOR SURVIVORS?

A personal narrative devoid of safety, predictability, and control

Being misunderstood as :

- ❖ Lazy

- ❖ In denial

- ❖ "Simply" depressed

- ❖ "Non-compliant"/poor follow-through

- ❖ "Treatment resistant"

- ❖ Not suitable for our interventions

- ❖ More stressed, powerless and isolated

WHAT DOES THIS MEAN FOR PRACTITIONERS?

There are multiple opportunities for intervention!

Some of the best interventions are

❖ small (in scope and time—they may be big in impact)

❖ personal

❖ directly address stress, powerlessness and social isolation by increasing:

CONTROL, CHOICE, & CONNECTIONS

EXAMPLES OF THINGS THAT ARE SMALL

❖ Recognize how she is exerting control (whether or not she discloses abuse)—this may help in a purely medical context, too.

❖ Check your verbal and body language for judgment of her situation or coping strategies.

❖ If you ask a question, leave time for an answer.

❖ Know three resources within your institution/agency that address these issues.

❖ Know three people outside your institution and agency that can help you and/or a survivor find what she needs (and have coffee or a call every six months).

EXAMPLES OF THINGS THAT ARE PERSONAL

❖ Remember something about her that is not related to the poverty, IPV, mental health issues and/or substance use.

❖ If you make a referral, make an appropriate one based on the survivor's situation: don't assume, for example, she needs or should want a referral to a social worker or psychiatrist or substance abuse counselor.

EXAMPLES OF THINGS THAT COUNTERACT THE PERNICIOUS THREE

Stress:

❖ Name it, normalize it and make connections with her health and other outcomes.

Powerlessness:

❖ Recognize how she is exerting micro-control. Work *with it.*

Social isolation:

❖ Encourage her to be part of something related or not to the issues.

❖ Have one person in your clinic or center be a liaison to the neighborhood organization (CDC, community center) so that there are fliers posted for block parties, community events, etc., and encourage your participants to go.

18

A FINAL NOTE

In our efforts to increase control, choice and connections, we must remember that these are individual manifestations of societal forces.

Systems – formal and informal – matter, so working on a purely individual level is not sufficient.