The Connection Between Violence, Trauma and Mental Illness in Women

Prepared by Heather Pollett
for the Canadian Mental Health Association,
Newfoundland and Labrador

Violence is behaviour that is used to intimidate and assert control over an individual and includes physical, sexual and emotional abuse. The victims of violence are disproportionately women and the medical cost of violence against women is calculated at $1.1 billion each year in Canada (Waters et al., 2004). While the immediate health effects of violence are highly visible in the short term--fear, bruises, broken bones and death are hard to ignore--it can also have profound long-term consequences for women's physical and mental health that are not always readily identified or understood. For example, exposure to violence may contribute to higher levels of stress, and tobacco may be used as a way of coping with that stress. In turn, smoking is a major cause of heart disease and cancer, and the stress can worsen existing health conditions or increase the risk of developing others (Doherty, 2002).

The health effects most commonly associated with violence are those that relate to emotional and psychological functioning. The relationship between trauma and mental health is a complex one, and a causal relationship is not immediately clear. Not all people who experience abuse, either in childhood or adulthood, inevitably develop mental illness, and not everyone who has been diagnosed with mental illness has experienced abuse. Yet the connection between trauma and mental health is well established. Research has shown that the rate of reported abuse in childhood and/or adulthood among women living with mental illness is alarmingly high: 80% of psychiatric inpatients have been physically or sexually abused (Rajan, 2004).

The different life experiences and roles of women--wife, mother and primary caregiver--combined with social and economic inequality have made women more vulnerable to violence throughout history. Just as women are more likely to experience violence than men, women are more likely to experience a mental disorder (CMHA, Ontario, 2003). Women also access mental health services differently and are diagnosed differently than men (Morrow & Chappell, 1999). For women, depression, anxiety, post-traumatic stress disorder, personality disorders, dissociative identity disorder, psychosis, and eating disorders are the problems most commonly associated with the experience of violence. Women also make 3 to 4 times more suicide attempts than men, but there is a "significant correlation between a history of sexual abuse and the life-time number

of suicide attempts, and this correlation is twice as strong for women as for men" (CMHA, Ontario).

The onset of mental illness in adulthood can be precipitated by trauma but due to differences in individual backgrounds, symptoms of mental illness can manifest themselves differently in each person and this makes it a challenge to pinpoint the exact nature and course of this relationship. It is suspected that women who are genetically predisposed to mental illness are at higher risk for developing symptoms earlier if they have experienced violence in childhood, and trauma may influence the severity of psychiatric symptoms (BC Partners, 2006). When combined with other adverse social and psychological stressors early in life such as poverty and substance abuse, the likelihood of developing mental illness further increases. One of the issues facing victims of violence is that mental health treatment is currently based on the traditional bio-medical model. This model focuses mainly on biological and genetic factors of mental illness and does not adequately take into account the social determinants of mental health such as poverty, housing and stigma (Morrow & Chappell, 1999). Nor does the bio-medical model fully consider the extent to which past experiences of violence influence the onset of mental illness in adulthood. All of these factors disproportionately affect women because of gender inequality (Morrow & Chappell).

Another issue is that the women who are most in need of mental health services often receive inappropriate diagnoses and treatment or are denied access to services because their behaviour is misunderstood or stigmatized -- “the diagnosis a woman receives can directly determine what forms of treatment she is eligible for within the mental health system, and will greatly impact on the type and extent of care she receives” (Morrow, 2002). For example, borderline personality disorder (BPD) is diagnosed in women at 3 times the rate of men (APA, 2000). It is a highly stigmatized diagnosis partly because its name implies that the problems stem from one's personality, which is seen as fixed and unchanging, and partly because of the nature of the symptoms. BPD is characterized by an unstable sense of self, feelings of emptiness, mood swings and self-destructive behaviour including substance abuse, self-mutilation, risky sexual activity, eating disorders and suicide attempts. It is believed that the

onset of BPD is influenced by genetic predisposition, a heightened sensitivity to stress, childhood abuse and neglect, and traumatic events in early adulthood. As adults these women often engage in dangerous behaviours or live in environments that may lead to violent situations such as rape, and between 40 to 70% of those diagnosed with BPD have been physically or sexually abused (NIMH, 2001).

The symptoms of borderline personality disorder are consistent with the emotional and behavioural responses of trauma survivors. Some mental health service providers who treat BPD believe that a diagnosis of complex post-traumatic stress disorder is more fitting than BPD because it takes into account the effects of violence (CMHA, "Violence and Trauma"). This is important because women diagnosed with BPD are sometimes seen as merely irritable, hostile, irresponsible and manipulative, and as a result are often deemed too difficult for mental health providers to treat. The unstable nature of the symptoms can make therapeutic relationships and a regular course of treatment such as weekly couselling and/or daily medication hard to establish and maintain (BPDRF). Consequently, a diagnosis of BPD may be considered treatment-resistant.

Whether it is the behaviour itself that makes borderline personality disorder difficult to treat, or the lack of research, training and resources to adequately cope with the disorder, it is possible that women with this diagnosis may find themselves in crisis situations more often and use more health and mental health resources. "Individuals with borderline personality disorder have more frequent hospitalizations, use outpatient psychotherapy more often, and make more visits to emergency rooms than individuals with other personality disorders" (PHAC, 2002). BPD also accounts for 20% of all psychiatric inpatients (APA, 2000). If the symptoms of BPD are not recognized as trauma-related and treated as such, then without effective intervention, these women may be at increased risk for violence or even suicide.

Misdiagnoses and inappropriate mental health treatment can reinforce self-destructive behaviours such as drug and alcohol use, which can then trap victims of abuse in the cycle of violence. When substance abuse is combined with poverty and inadequate housing, the trap grows even tighter. Drug and alcohol use can be a coping strategy for women living with violence,

a way to numb themselves and block out painful memories of past violence. For women living with mental illness, substance use can be a form of self-medicating when prescribed psychiatric medication is ineffective or has unpleasant side effects. When mental illness and substance abuse occur at the same time they are known as concurrent disorders. "Substance misuse may induce, worsen, or diminish psychiatric symptoms, complicating the diagnostic process" (BC Partners, "Concurrent Disorders"). Not only can they receive inappropriate diagnoses, but people with concurrent disorders may also be unable to access the treatment they need because many providers only treat mental illness and substance abuse separately. For those who need treatment for mental illness and addictions at the same time, waiting lists for these services may be too long (BC Partners). Because drug and alcohol use impairs judgment and makes it difficult for those with mental illness to get treatment, concurrent disorders may, if left untreated, lead to violent behaviour (BC Partners, "Mental Disorders").

The media reinforces many of the negative public attitudes about mental illness. The extent to which people with mental illness are the perpetrators of violence is sensationalized in news reports, and the misconception that mental illness is unpredictable and, therefore, inherently dangerous pervades entertainment and popular culture (Arboleda-Flórez, 2003). Schizophrenia is the mental illness popularly associated with violence and dangerous behaviour because of its characteristic disturbances in thinking and perception, a condition known as psychosis. Hallucinations and delusions, for example, are symptoms of psychosis and can cause a person to act in inappropriate and unpredictable ways if left untreated. However, not all people who exhibit psychotic symptoms have schizophrenia and, while studies indicate that there is a relationship between certain symptoms of psychosis and violence, not all people who have psychotic symptoms are violent (BC Partners, "Mental Disorders").

Statistically, people with schizophrenia, or any other mental illness, are not the main perpetrators of violence in society. In fact, people living with mental illness are 2.5 times more likely to be the victims of violence than those without mental illness (CMHA, 1996). Stronger predictors of an individual's likelihood to commit future violence are a history of violent and criminal behavior, childhood abuse, and certain personality traits that are found not only in those

with mental illness, but also in the general population (BC Partners, "Mental Disorders"). When the mentally ill are perpetrators of violence, a combination of past trauma, poverty, current living situation and substance abuse--all of which are further compounded by marginalization and discrimination--can make a person more vulnerable to experiencing violence, and more vulnerable to becoming violent if they are provoked. As with all mental illnesses, symptoms of schizophrenia can be triggered or worsened by trauma, living in a stressful environment, or substance use (SSC). Therefore, acts of violence committed by those with schizophrenia, or any other mental illness, are not necessarily a direct result of their symptoms (CMHA,1996; Arboleda-Flórez, 2003). With appropriate treatment, people with mental illness are no more likely to be violent than the rest of the population.

Women who do not receive appropriate intervention for violence, mental health and substance abuse issues may fall through the cracks and, eventually, end up in the correctional system. Criminal behaviour is influenced by the experience of violence and women in prison report a higher rate of violence than the general population. In Canada, 82% of federally sentenced women have reported past sexual and/or physical abuse; this rises to 90% percent for Aboriginal women (VPI, 2006). Women in prison also have higher rates of mental illness than their male counterparts, some of which is associated with abuse in childhood and continuing abuse in adulthood (CAEFS, 2006; Laishes, 2002). Female offenders are also more likely to be re-victimized by violent men (CAEFS, “Long Term”).

Violence prevention, intervention and mental health promotion is important for women who have mental health issues and have been victims of violence because they are the most vulnerable to re-victimization once they become ill, both at the hands of abusers and by the mental health service providers and justice system that purports to help them (Morrow, 2002). Because women with mental illnesses often have to trust and rely on other people as caregivers, there are more opportunities for them to be abused both in their homes and in institutions. They may even be traumatized by the process of getting help and, if they do not feel that the services put in place can help them, they may be discouraged from seeking assistance in future crisis situations or stop current treatment. A lack of understanding and sensitivity by health care

providers and police may reinforce negative thinking and self-destructive behavioural patterns. Thus, the cycle of violence is allowed to continue.

Not all mental health issues neatly fit current diagnostic criteria or constitute a significant impairment of normal functioning such that it requires labelling, medication or hospitalization. Trying to fit trauma survivors with mental health issues into the current bio-medical model of treatment rather than tailoring services to individual needs negatively affects the provision of appropriate treatment. Often, behaviour is stigmatized, pathologized or criminalized, and symptoms are assessed in isolation without considering the social context of women's lives and without taking into account a history of violence. Even if assessment and treatment are informed by trauma, there are not enough resources to effectively deal with the problem. An inefficient use of health care and law enforcement resources means that the economic burden of inappropriate treatment is carried not only by those who need these services most, but also by society as a whole. Although violence against women may cost over a billion dollars each year, the true cost is much higher, and the magnitude of the suffering is immeasurable.

Negative public attitudes and biases in health care need to be acknowledged so that the stigma associated with violence, mental illness and substance abuse is eliminated. Stigma helps to perpetuate violence because it is a barrier to treatment for mental illness and it obscures the real causes of violence. Identifying the roots of violence and addressing its far-reaching consequences and long-term health effects can help break the cycle by providing better treatment options to those already affected, and by preventing future violence from occurring.

References

American Psychiatric Association (APA). (2000). *Diagnostic and Statistical Manual of Mental Disorders*. Fourth Edition, Text Revision.

Arboleda-Flórez, J. (2003, November). Considerations on the Stigma of Mental Illness. *The Canadian Journal of Psychiatry.* Vol. 48, No 10. Canadian Psychiatric Association. [Online]. Cited August 11, 2006: http://www.cpa_apc.org/Publications/Archives/CJP/2003/November/guesteditorial.asp

BC Partners for Mental Health and Addictions Information. (2006). Childhood Sexual Abuse: A Mental Health Issue. [Online]. Cited September 6, 2006: http://www.heretohelp.bc.ca/publications/factsheets/child_sexualabuse.shtml

BC Partners for Mental Health and Addictions Information. (2006). Concurrent Disorders: Mental Disorders and Substance Use Problems. [Online]. Cited September 6, 2006: http://www.heretohelp.bc.ca /publications/factsheets/concurrent.shtml

BC Partners for Mental Health and Addictions Information. (2006). Mental Disorders, Addictions and the Question of Violence. [Online]. Cited September 6, 2006: http://www.heretohelp.bc.ca/publications/factsheets/violence.shtml

Borderline Personality Disorder Research Foundation (BPDRF). About the Disorder. [Online]. Cited September 30, 2006: http://www.borderlineresearch.org/about_disorder/index.html

Canadian Association of Elizabeth Fry Societies (CAEFS). (2006). Health and Mental Health. [Online]. Cited September 15, 2006: http://www.elizabethfry.ca/eweek06/pdf/menthlth.pdf

Canadian Association of Elizabeth Fry Societies (CAEFS). Long Term Effects of Abuse and Trauma. [Online]. Cited September 15, 2006: http://www.elizabethfry.ca/eweek06/pdf/effects.pdf

Canadian Mental Health Association (CMHA). (1996). Violence and Mental Illness. [Online]. Cited September 9, 2006: http://www.cmha.ca/bins/content_page.asp? cid=3-108&lang=1

Canadian Mental Health Association, Ontario. Violence and Trauma. [Online]. Cited September 29, 2006: http://www.ontario.cmha.ca/content/about_mental_illness/women.asp?cID=6153

Canadian Mental Health Association, Ontario. (2003). Women and Mental Illness. [Online]. Cited September 10: http://www.ontario.cmha.ca/content/about_mental_illness/women.asp?cID=3974

Doherty, D. (2002). Health Effects of Family Violence. National Clearinghouse on Family Violence. Health Canada.

Laishes, J. (2002). The 2002 Mental Health Strategy for Women Offenders. Correctional Services
Canada. [Online]. Cited September 13: http://www.csc scc.gc.ca/text/prgrm/fsw/mhealth/mhealth _e-01.shtml

Morrow, M., & Chappell, M. (1999). Hearing Women's Voices: Mental Health Care for Women. The British Columbia Centre of Excellence in Women's Health. [Online]. Cited September 8, 2006: http://www.bccewh.bc.ca/PDFs/hearingvoices.pdf

Morrow, M. (2002). Violence and Trauma in the Lives of Women with Serious Mental Illness: Current Practices in Service Provision in British Columbia. The British Columbia Centre of Excellence in Women's Health. [Online]. Cited September 8, 2006: http://www.bccewh.bc.ca/PDFs/ violencetrauma.pdf

National Institute of Mental Health (NIMH). (2001). Borderline Personality Disorder: Raising Questions, Finding Answers. [Online]. Cited September 29, 2006: http://www.nimh.nih.gov/publicat/bpd.cfm

Public Health Agency of Canada (PHAC). (2002). A Report on Mental Illnesses in Canada. [Online]. Cited September 30, 2006: http://www.phac-aspc.gc.ca/publicat/miic-

mmac/chap_5_e.html

Rajan, D. (2004). Violence Against Women with Disabilities. National Clearinghouse on Family Violence (NCFV). [Online]. Cited September 20: http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/2005femdisabl_e.pdf

Schizophrenia Society of Canada (SSC). What Is Schizophrenia? Cited October 1, 2006: http://www.schizophrenia.ca/files/What_Is_Schizophrenia.pdf

Violence Prevention Initiative (VPI). (2006). Facts on Violence: Violence Against Women. Government of Newfoundland and Labrador. [Online]. Cited September 13, 2006: http://www.gov.nf.ca/vpi/facts/women.html

Waters, H., Hyder, A., Rajkotia, Y., Basu, S., Rehwinkel, J.A., & Butchart, A. (2004). The Economic Dimensions of Interpersonal Violence. Department of Injuries and Violence Prevention, World Health Organization. [Online]. Cited September 26, 2006: http://whqlibdoc.who.int/publications/2004/9241591609.pdf