CURIOSITY LIES IN WAIT FOR EVERY SECRET

Jennifer Holly reminds drug workers of the high incidence of violence in the background of women with substance misuse and mental health problems.

Most drug workers know that the majority of those people with serious drug and alcohol problems also struggle with their mental health and the impact of trauma often going back to childhood. Workers know this instinctively, but don't always make the day-to-day connection between a client's lifetime experiences of trauma and current behaviour which may be challenging or frustrating. Clients may repeatedly put themselves in situations which are clearly risky. And this seems a particularly acute problem for women service users. As one alcohol worker recently told me: "clearly there's a history of abuse, from childhood, and now she goes from relationship to relationship. Each time there's abuse. I don't know how to help her out of the situation." So what is the psychiatric fallout for women drug and alcohol users whose lives have been blighted by sexual and violent trauma? Why can it be so difficult to break the cycle of abuse?

It isn't hard to imagine that being physically assaulted, being raped (sometimes in front of your children), being told you're fat, ugly, stupid, worthless or pointless, being isolated from friends and family and having your whereabouts constantly monitored, could leave a survivor feeling – among other things – sad, terrified, on edge, ashamed, lacking self-esteem, confused and angry.

It also translates into above average psychiatric diagnoses. Women who have experienced abuse or serious sexual assault are roughly three to five times more likely than non-abused women to experience depression, anxiety and suicidal thoughts. Around 64% of abused women also experience post-traumatic stress disorder (PTSD), significantly more than the 1-2% lifetime prevalence in the general population.

Prolonged abuse over months and years may also be followed by another syndrome knows as complex PTSD. In addition to the symptoms of regular PTSD, i.e. intrusive memories and flashbacks, avoidance, feelings of numbness and extreme edginess, complex PTSD is also characterised by difficulties in regulating emotions, explosive anger, inhibited sexuality, feelings of 'unreality', changes in view of self, feeling helpless/defiled/violated, having a belief that no-one can understand, difficulties in intimate relationships, distrust, repeated failures of self-protection, experiencing hopelessness and despair.

It's worth considering the overlaps between the symptoms of complex PTSD and those associated with borderline personality disorders (BPD). There is a question mark around BPD diagnoses and whether, in some cases, it is a misdiagnosis of complex PTSD. Taking into consideration that up to 90% of people diagnosed with BPD have experiences of severe childhood trauma, and around half meet the criteria for co-morbid PTSD, there is certainly reason to consider whether service users who have a BPD diagnosis are actually responding to a childhood trauma which may have been compounded by abuse in adulthood.

Survivors of domestic and sexual violence frequently describe feeling scared, anxious and/or depressed for years after the end of an abusive relationship. PTSD symptoms last, on average, for twenty years. For some

survivors, it may become the 'norm' to live with psychological distress, compounded by the resulting effects of abuse such as poor physical health, poverty and a lack of safe affordable housing. It may not be obvious to them that being the victim of abuse, possibly decades previously, could be the source of their current mental ill-health and substance use. They may be left to simply cope and survive alone.

Self-medicating, to cope with experiences of abuse and to relieve some of the physical and emotional pain caused by domestic and sexual violence is commonplace. Women who have experienced domestic and sexual violence are just over four times more likely to have a lifetime substance use disorder than women who have experienced no trauma, with victims of multiple forms of abuse reporting higher levels of substance use than those who have experienced just one form of violence. Women who have experienced more than one sexual assault are 3.5 times more likely to begin or increase substance use. In terms of survivors of violence and abuse, problematic substance use tends to be preceded by mental illness, and is used to manage the symptoms. Alcohol and other depressants, for example, can medicate poor sleep, mask extreme anxiety and cope with the intrusive symptoms associated with PTSD.

Considering how many women's substance use may be associated with their experiences of domestic and/or sexual violence and subsequent long-term psychological distress, it is vital that drug and alcohol workers are encouraged and have the confidence to be curious about their service users' experiences of abuse. Not understanding how domestic and sexual violence could be linked to someone's substance use can definitely hamper their ability to stabilise their use or recover. Furthermore, not asking about domestic and sexual violence can leave survivors – and their children – at risk of further harm. The Department for Education's recent publication *Children's Needs –Parenting Capacity* clearly evidences how a combination of parental mental ill-health and problematic substance use increases the risk to children's safety and welfare, but most importantly that *"the best predictor of adverse long-term effects on children is the co-existence with family disharmony and violence"*. So how best to support survivors of sexual abuse and domestic violence?

Fiona (not her real name) told me about her experiences of domestic violence:

"My ex-husband was really quite violent. So were a couple of other exes. One really beat me up, punched me in the nose. Others stole money, managed to raid my bank account. When I was drinking, it was a way to cope with what was going on. I didn't seem to mind so much when I drank. Drinking also gave me the courage to fight back. Leaving the last guy, I was terrified. I thought he would kill me and the kids. He wouldn't let me take both my children when I went out – I guess a way of keeping me coming back. So I had to wait until he'd passed out from drinking before we could all get away together. I got to a friend's house, called the police and eventually got a restraining order against him."

WOMEN WHO HAVE EXPERIENCED DOMESTIC AND SEXUAL VIOLENCE ARE JUST OVER FOUR TIMES MORE LIKELY TO HAVE A LIFETIME SUBSTANCE USE DISORDER

Fiona is clear that the first thing a survivor needs "is to be treated like a human being, like you're worth treating. Asking for help is the most difficult thing you can ever do, especially for women who tend to have lower self-esteem than men. It's really difficult to tell someone you're an alcoholic, a drug addict, or your husband beats you up. It makes you feel worthless. When you do say something, you just want someone to say, 'Look, it's not your fault, you are not a worthless human being. You do deserve to live, you deserve to be a mother, you deserve to be happy, you don't deserve this man smacking you round the face'. That's the first thing you need. And then you need the practical help."

In terms of practical support, agencies should support workers to effectively assess the risk of further violence. There is a standard risk assessment – the DASH (Domestic abuse, stalking and harassment) Risk Identification Checklist – which is widely used by the police and specialist domestic violence services. The risk assessment form can be downloaded from www.dashriskchecklist.co.uk or contact your local domestic violence service/forum for a local version as well as risk assessment training for staff.

If your client is assessed to be at high risk, s/he can be referred to the MARAC (multi-agency risk assessment conference) where the case is discussed by a range of agencies such as the police, housing, specialist support services and actions will be agreed.

The next step requires more curiosity – asking survivors what they want. Survivors will be at different stages of change. Some survivors will want to stay in the relationship (for many different reasons), or won't be ready to leave. In such cases, you can support a survivor through safety planning. You can find out about safety planning from your local domestic violence service or in the *Survivors Handbook* on the Women's Aid website: http://tinyurl.com/7w4hye5). You can provide information about local services in case she later decides to access support.

Other survivors will want the relationship to end and to remain in their home. Safety at home can be increased through occupation orders (which remove the perpetrator from the property) and non-molestation orders (which require perpetrators to have no contact with the victim), and the use of Sanctuary Schemes (security measures for a property). Your local domestic violence service can advise survivors on what measures are available locally and how to access them, as well as offering other practical and emotional support.

For some survivors, it may not be possible to stay in their home. Depending your client's level of substance use, you may consider referring her to a refuge (the National Domestic Violence Helpline on 0808 2000 247 can provide details of which refuges have spaces at any time). Many refuges are unable to support women with complex needs such as substance use problems. If you cannot find refuge space, domestic violence advice or outreach services should be able to support your client to access local authority accommodation.

The good news is that, in many ways, we already know the answer to the problem. There is no magic wand, no new whizz-bang model of working. We simply need to do what we are already doing, just a little bit better. And with a tad more curiosity.

Jennifer Holly coordinates the Stella Project Mental Health Initiative, a three-year project developing models of responding to survivors and perpetrators of domestic and sexual violence who are also affected by problematic substance use and/or mental ill-health.

For more information, please visit http://www.avaproject.org.uk/our-projects/stella-project.aspx.