The National Alliance on Mental Illness defines mental illness as a medical condition that disrupts a person’s thinking, feeling, mood, ability to relate to others, and daily functioning. Examples of mental health conditions include depression, anxiety, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder and post traumatic stress disorder (NAMI, 2009).

Warshaw (2010) defines a mental health issue as a situation or concern involving alterations in thinking, feelings and/or behavior, associated with emotional distress and/or difficulties in functioning that the individual and/or others want to resolve. A mental health issue becomes a psychiatric disability when the effects of trauma and/or mental illness significantly interfere with the performance of major life activities. Psychiatric disabilities may come and go, remit, or become more persistent.

About one in four adults experiences a mental health condition in a given year, according to the National Institute of Mental Health. One in 17 lives with a serious psychiatric disability, such as schizophrenia, major depression or bipolar disorder (NAMI, 2007).

The role of trauma in mental illness

While not all mental illnesses are caused by traumatic experiences, trauma may cause or exacerbate some mental health conditions.

Individuals living with chronic mental illness experience higher rates of abuse, while those abused in childhood experience higher rates of psychiatric symptoms as adults (Warshaw, 2010). Many behaviors and responses seen as “symptoms” by advocates and other providers are directly related to traumatic experiences that cause mental health concerns (NCTIC, n.d.):

- Depression, post-traumatic stress disorder, anxiety and panic disorder are common among people in domestic violence shelters (Warshaw et. al., 2003).

- Individuals experiencing any type of domestic violence are nearly three times more likely to report symptoms of severe depression (Warshaw, 2010).

- As many as 90 percent of people who have severe psychiatric disorders are survivors of at least one incident of trauma during their lifetimes (Akers et. al., 2007).

- Studies have found that up to 53 percent of people who seek services from public mental health centers report childhood sexual or physical abuse (Huckshorn, 2004).
In one study, 90 percent of women hospitalized post-suicide attempt reported current severe domestic violence (Warshaw, 2010).

In another study, 90 percent of people with mental health issues had been exposed to trauma, and most had multiple experiences of trauma (Huckshorn, 2004).

When trauma survivors develop psychiatric problems, systems of care often perpetuate traumatic experiences through invasive, coercive or forced treatment that causes or exacerbates feelings of threat, a lack of safety, violation, shame and powerlessness (NCTIC, n.d.).

**Barriers to service**

According to the U.S. Department of Health and Human Services, fewer than one-third of adults with a diagnosable psychiatric disorder receive any mental health services in a given year. Racial and ethnic minorities are even less likely to have access to mental health services and often receive a poorer quality of care (NAMI, 2007). People with mental health issues may encounter a number of barriers when seeking help:

- **Stigma.** The single most pervasive factor affecting access to and participation in services is the stigma accompanying mental health issues. Individuals with psychiatric symptoms often encounter people who avoid or shun them because of myths about mental illness.

- **Trust issues.** People may be reluctant to share mental health concerns with advocates or other providers for fear of being discounted. Others may have suggested they have a distorted view of reality, especially if they bring up problems or issues that make others uncomfortable. Abusive partners or parents may encourage people with mental health issues not to trust their own judgment or perceptions, and providers may sometimes do this as well.

- **Reliance on imported mental health providers to rural or underserved areas.** People may also be reluctant to trust itinerant service providers who may not remain long enough to provide continued services. This can lead to fractured therapy. Trust barriers are compounded if such providers do not understand local customs, diversity issues, intergenerational trauma or history of disparity of treatment to marginalized victims (Holley, 2011).

- **Fear of losing autonomy.** Providers in the past may have suggested that people with mental health conditions are incompetent to make their own decisions, or lack the insight to know what they need. Such providers may have used this perception as a reason to impose their own solutions, push medications or force hospitalization. A survivor shares:

  “I went to therapy several times, and I went to doctors and emergency rooms, and they all put me on pills. I had a hard time with that. Most of the therapists I’ve seen,
SAFETY ISSUES: MENTAL HEALTH CONCERNS

For individuals experiencing interpersonal violence, psychiatric symptoms can have an impact on safety:

• Accurate assessment of danger may be impacted by thought disorder symptoms (Bland, 2007). Traumatic brain injury or mental health symptoms can impair judgment and thought processes (including memory), making safety planning more difficult. People with psychiatric symptoms may be reluctant to seek assistance, because they fear being labeled, institutionalized or medicated.

• Mental and physical problems, whether temporary or more long-term, can diminish some people’s ability to work, participate in job training or education programs, or comply with government benefit requirements (Davies, n.d.). All of these factors can make it harder to escape violence.

• Trauma symptoms can mimic mental illness, and trauma survivors may be misdiagnosed when the traumatic effects of abuse aren’t taken into account (Warshaw, 2010). Examples include survival strategies seen as disorders (“over-reaction” to minor stimuli versus acute social awareness) and “symptoms” that are actually an appropriate response to ongoing danger or victimization. This could lead providers to focus too much on obvious psychiatric symptoms and fail to see the danger posed by the individual’s situation. Shirley Moses, Shelter Manager at the Alaska Native Women’s Coalition in Fairbanks, AK, says:

  “They can see that the person is distraught, and not able to function on a daily basis, but they don’t recognize the things that are going on. They look at what they think might be wrong and they assume there are mental health issues. It might just be a situation where the person had a breakdown. They’ve finally had enough and they show symptoms of mental illnesses, but it’s situational. They are trying to deal with domestic violence or sexual assault and they are overwhelmed. They are at a loss as to what they can do” (Moses, 2010).

• Abusers use mental health issues to discount their victims or control them. Behavioral health specialist Karen Foley says:

  “I have someone who is unable to take her medication because her partner can control her better when she’s not medicated. There are also a lot of people I work with who make appointments for therapy and are not able to follow through with those appointments. Some of that, I think, stems from the fear of letting out those family secrets. Other people barge in on their family member’s mental health therapy appointments and call it family therapy, and the individuals end up in a very dangerous position if they reveal anything. At best they keep quiet and no real therapy happens” (Foley, 2010).
you can’t see them without seeing the pill doctor first. Some people do need meds. But I felt like I got used and abused by the pharmacy as a guinea pig. Is this going to work? Is that going to work?”

• **Fear of losing children.** Parents may fear they will be judged too incompetent, violent or even dangerous to provide adequate parenting because of psychiatric issues (Nicholson et. al., 2001). Fear of losing custody can keep a parent from acknowledging mental health problems and requesting services.

• **Too much focus on deficits rather than strengths.** Services tend to be deficit-based, often available only when people with mental health concerns have diagnosable symptoms or when abuse or neglect of their children has been documented. A focus on deficits and the assumed inadequacies of people with psychiatric issues, rather than their strengths, contributes to a cycle of hopelessness and a view of the “helping” relationship as adversarial (Nicholson et. al., 2001).

• **Lack of affordable services.** People with mental health concerns may be unable to afford services if they do not have insurance or have an insurance policy that doesn’t adequately cover mental health services. This can be a problem for people with middle-class incomes as well as people who live in poverty. Managed care policies may try to limit the type or amount of services that are covered by insurance.

• **Behavior that poses challenges for staff.** A person with psychiatric issues such as complex trauma, bipolar disorder or schizophrenia may behave in ways that are perceived as disruptive, particularly in a shelter or a residential facility.

### Empowering people with mental health issues

Most of the primary skills advocates use with people affected by mental health issues are no different from those used with any other survivor. But there are specific things to know about the needs, reactions, symptoms and experiences of survivors who have a psychiatric disability. Pease (2010) lists some common experiences of persons with mental illness:

• **Difficulty with thinking and processing.** Anxiety, depression, medication, disturbing thoughts or cognitive difficulties may interfere with concentration.

• **Difficulty managing feelings or interaction with others.** The survivor may have strong reactions to “minor” irritants, may react to small criticisms or suggestions in ways that seem extreme, or may disengage, not addressing conflicts or problems.

• **Difficulty screening out stimuli.** Both external and internal stimuli may be distracting and disorganizing to the person you are working with.

• **Low stamina.** The person may “run out of steam” in meetings or sessions, withdraw
from activities, give little attention to the children, or be unable to complete tasks and chores.

Safety and support can reduce psychiatric disability for trauma survivors (Warshaw, 2010). Here are some ways to empower people with mental health concerns:

- Respond to people, not diagnoses. When looking at a trauma survivor’s symptoms and behaviors, ask: How do these things make sense? How do they help? How can we help this person make the changes they want? What would this person need in order to cope without these symptoms? (Pease, 2010).

- Recognize that domestic violence, trauma and psychiatric disability are linked, and the pain of trauma and violence can be disabling for some survivors. Responding to that pain need not disempower survivors nor disregard their strength – we should not require survivors to resolve the pain of their experiences on their own before we offer them support and advocacy for the violence or abuse they have experienced (Pease, 2010).

- Don’t make people feel guilty or wrong for coming to you for help. If lack of appropriate training or credentials prevents you from answering a question (about medications, for example) or providing a certain kind of assistance, explain this. Make an appropriate referral and emphasize that people are not wrong for coming to you with this particular problem. Make it clear that you will help them figure out who can provide the needed help and are happy to explore options.

- Set respectful boundaries. If someone seems to engage in “attention seeking behavior” by making repeated demands on your time, explain that you have a conflict that prevents you from talking at the moment. But assure the individual that you will give them your undivided attention if they come back at a designated time.

- Believe people who tell you about traumatic incidents, even if they seem confused or out of touch with reality, or say something you perceive to be inaccurate. Try asking yourself, “What might be happening to make this seem true for this individual?” Consider how some behaviors and beliefs make sense or could be a reasonable response to multi-

### A survivor of multi-abuse trauma discusses what she feels was pressure to use medications:

“I went to therapy several times, and I went to doctors and emergency rooms, and they all put me on pills. I had a hard time with that. Most of the therapists I’ve seen, you can’t see them without seeing the pill doctor first. But I felt like I got used and abused by the pharmacy as a guinea pig. Is this going to work? Is that going to work?”
abuse trauma. Don’t ask, “Why are they acting this way? Instead ask, “What happened to them to trigger this response? How can I help them find safer ways of coping that cause less grief?” Abusers often manipulate their victims to doubt their own perceptions by convincing them that they are “crazy” (Foley, 2010).

• Clarify the appropriate role of 12-Step groups for people who use them. Some people report that their sponsor or 12-Step group has tried to discourage their use of medications to treat mental illness. Providers should point out that Alcoholics Anonymous itself takes no official stance on the use of prescription medications. Also point out that 12 Step groups are not meant to be a substitute for therapy. Tia M. Holley reports:

  “As a substance abuse counselor here in Alaska, I have seen people in recovery feel pressured to be 100 percent substance free, quit taking needed psych meds and then go on to commit suicide. This pressure can come from peers in recovery groups, or from family who believe that the substance use was creating the mental illness” (Holley, 2011).

• Pay attention to accessibility issues (Warshaw & Pease, 2010). Mental illness is covered under the Americans with Disabilities Act, and reasonable accommodations should be made where needed. Examples of accommodations include allowing a longer time to achieve certain goals or complete tasks, part-time rather than full-time work, extra privacy, and attention to sensory issues.

• Examine medication policies to ensure survivor autonomy and control. While some survivors welcome medication to manage symptoms and improve their ability to function, others may have legitimate reasons for not wanting to take medication. Concerns may include fear of side effects, worries about long-term effects, or distrust of current research on medication safety (Pease, 2010). Pease points out that if we refer for medication to change a survivor’s behavior, help a survivor “fit in” to a program or make other staff/residents more comfortable, we are exercising power and control. Ideally, each individual should have access to their own locked medicine cabinet in their own room.
● Be aware of the ways an abuser can use mental health issues against a victim (Pease, 2010). Perpetrators often convey the message that their victims deserved abuse because they were “acting crazy.” Make it clear to people who have been victimized (and to other providers) that nobody deserves violence or abuse, no matter what else is going on.

● Also be aware of the ways batterers use mental health issues to control their partners – for example, control of medications, coerced overdose, control of treatment, undermining credibility and attacking parenting skills. Warshaw (2010) points out that this works because of the stigma society attaches to mental illness.

● Safety planning should address mental health-specific issues – i.e., medication, control of treatment decisions, and what to do if symptoms keep individuals from being able to advocate for themselves – as well as general safety issues (Pease, 2010).

● Affirm autonomy and the right to control decision-making. Affirming people’s right to make their own choices that are right for them is especially important in light of the fact that an abuser (or even other providers) may have implied they lacked the insight or capability to make their own decisions.

● If psychiatric hospitalization becomes necessary, determine what supports you can offer such as calls, visits and continued services. With permission, and if a release of information has been signed, discuss safety concerns with hospital staff such as allowing the person to refuse calls or visits from the abuser, and safety planning on discharge (Pease, 2010).

Working with other providers

When working with mental health providers:

● Refer to providers that incorporate trauma-informed care into their services. Trauma-informed care is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services (Huckshorn, 2004).

● The Wellness Recovery Action Plan™ (WRAP) used by many mental health professionals lends itself well to safety planning for domestic violence issues as well as mental health issues. WRAP is a structured system for monitoring symptoms through “Advance Directives” – i.e., “If I cannot advocate for myself, please do this … and not this. Involve this person … and not this one.” Advance Directives can afford protection if they keep an abuser from being involved in treatment decisions (Pease, 2010).

● Training for mental health providers should include the dynamics of domestic violence/sexual assault, the importance of not blaming victims, tactics abusers may use to control or interfere with treatment, the importance of not overemphasizing the role of
medication, and the dangers of couples counseling under the family systems model when one partner is an abuser (Warshaw, 2010).

• If possible, cultivate a pool of private practice therapists willing to accept one or two people or families on a pro bono basis. This can be particularly helpful for individuals who need family therapy for themselves and their children in communities where public mental health centers separate adults and children into separate programs because of funding constraints.

References


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