A Conversation About… Family Violence and Mental Health – Part 1

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

Sabin Fernbacher (00:17):

Welcome to this episode of MHPN Presents a conversation about. My name is Sabin Fernbacher and I work as an independent consultant as a trainer, and also teach a family violence subject at Monash University. I'm passionate about women's mental health as well as trauma, and I'm delighted to be joined by Louise Newman, a psychiatrist who works with complex trauma and who's an advocate for women's mental health services. Hi Louise, and thanks for joining me.

Louise Newman (00:47):

Hi, Sabin. Great to be here and involved in this podcast.

Sabin Fernbacher (00:51):

I would like to begin by acknowledging the traditional owners of the land that Louise and I are on today. That is the Wurundjeri and the Bunurong people of the Kulin nation. We are both in Naarm that's also known as Melbourne. I would also like to pay my respect and our respect to their elders past, present, and future. I acknowledge First Nations people's strength, their resilience and ongoing connection with land, waters, and communities. And I acknowledged that sovereignty of these lands was never seeded. Given the topic of our conversation today, Louise, I also, and we also want to acknowledge people with a lived experience of both family violence and mental health challenges as well. So today we're talking about family violence and mental health and when I was invited to do this podcast, the first person that came to my mind to join me was you, Louise.

(01:42):

And that is for a number of reasons, of course, your longstanding commitment to working in trauma and mental health on a number of levels and your advocacy for women's mental health services and

women's mental health and trauma survivors, your clinical work, your systemic work. You've published extensively and you advise government, both state and national on mental health services from practise to policy. And I've had the good fortune to work with you on some of those policies on the state level and if so, appreciated our collaboration and of course you continue your clinical work and advocacy in this area today and beyond. And that's just only mentioning a few of your work that you bring to this area. When we were preparing to do this podcast, to have this conversation together, we are trying to remember when we first met. I'd followed your work for quite some time.

(02:32):

And then I recall that our first conversation, which was a study around supporting people with trauma experiences and what we really discovered there were our shared values in supporting people with a lived experience of trauma and mental health challenges and making services more accessible and better and more responsive to them and for them. Since then, we've done some work together and also caught up to talk about trauma and mental health on all levels, individual systemic policy and research and working for me, working within the system, but also now as an independent consultant. Those conversations and catch-ups really anchored me and I always walked away encouraged to keep going with my work in that area. And I hope I've told you that before, but if I haven't, I'm telling you now.

Louise Newman (03:19):

Thank you very much. No, and I think what it all says to me is that we are still going and that's what all of us working in this area need to acknowledge that there's a long way to go, but the commitment and determination of people to help women and children particularly is really significant and that empowers us in terms of this actual struggle that we're involved with.

Sabin Fernbacher (03:44):

It does indeed. Absolutely. And I was thinking, you are such a kindred spirit to me, and I know I seek out other people in this work that we connect because I think we all need support in this area sometime because there's a lot of work still to do.

Louise Newman (03:57):

Look, exactly. This is for everyone involved in these sorts of issues. They're hard issues, they're emotionally very demanding. Sometimes we all need a break or rest is hard going. So having people that we can share these things with and actually have similar values is really crucial.

Sabin Fernbacher (04:17):

It is, isn't it? So that's maybe also a reminder for people who listen to this podcast, if you are working in this space, make sure that you also have good support and find kindred spirits and people who are wanting to and committed to work in this area because sometimes it's tough. So in today's conversation we are talking about one part of, I suppose, trauma and mental health, and that's family violence as we've called it. Family violence and mental health. And I'll talk a little bit in a moment around terminology as well, but in this podcast we are hoping to explore a little bit about family violence and mental health. We'll talk about that. Some of the complexities, some of the challenges, some of the issues. We'll also touch on trauma-informed care, what it is, what it's not, and some of the issues within that area of work.

(05:01):

And we'll also touch a little bit on gaslighting in this context as well. We could talk about this for days, couldn't really isn't we Louise? And we have, but we also know that we have a second podcast coming up and if we don't cover some issues, we can follow up in the second podcast on that next time as well. As we start talking about family violence and mental health, I just wanted to remind everybody that there's different terminology that different people but also different states and jurisdictions use. Most people who listen might be familiar with the term domestic violence. That was a term coined into sort of seventies, eighties when that kind of violence within the home was kind of more made public. It used to quotation mark happened behind closed doors, so to speak. And it was really the feminist movement that opened that door and said, we need to talk about this publicly.

(05:52):

Often what was then referred to as domestic violence was really about intimate partner violence. So a partner most often a male, but not always using violence against their partner or also children in some jurisdictions for example, we're based in Victoria, Victoria State government certainly. And organisations as well now talk about family violence and the definition of family violence is much broader to intimate partner violence or domestic violence. So it encompasses a range of types of relationships and people using violence against another person and also a range of types of violence. So it's just a reminder that in different contexts and different states, you might come across different terminology. Some states are known, new South Wales uses domestic violence and family violence together whilst other might use one or the other term. I hope you're still with us on this. It already shows some complexities in this space, doesn't it? Louise?

Louise Newman (06:51):

Yes. Look, I just say from my perspective, it's a really good thing that we are broadening definitions from the sort of narrow focus about things like violence and sexual assault within marriage, which this whole discussion started with, which was very appropriate and obviously needed to be spoken about to more varied and diverse family and relationship situations. But the thing I would add is that that's still the current terminology in many ways to my mind capture the sort of epidemic we have of violence largely against women on the streets by people that they don't know or are not related to. So not necessarily relationship in a traditional way, but there's a culture of violence against women. I mean, and some people of course have described that as almost a rape culture where there's a level of sexual assault and violence that is acceptable and certain values, essentially patriarchal systems are used to justify that in a way.

(07:54):

So it is broadening because that is such a huge issue that we're facing, although the complexity is still there in that the majority of deaths of women in these situations and very serious outcomes for women and children are with current or ex-partners as we all know. But I think it's a real concern, particularly for young women who are wanting to go out, have fun, meet people and so on and take risks and sometimes can be assaulted by strangers. So I think the trick for us working in the area is to really describe better what women and girls are experiencing in their interpersonal lives.

Sabin Fernbacher (08:42):

Yes Spot on the term that I didn't bring in, which you've just done is violence against women and or children, isn't it? And listeners will also have come across it. And of course in the last two years we've heard about it in parliament, in the prevention space of preventing violence against women. There is a lot of work being done on that continuum of enabling societies, what supports under violence behaviours, that being I suppose to a degree tolerated and also all those connections as well. Absolutely. So we need to always think of all of that when we work in this space.

Louise Newman (09:17):

I think so because this is an issue that just doesn't affect people in so-called stable relationships or longer term relationships. It can be casual connections, one-off events. But the underlying issue as I see it, is that our systems of response and our levels of understanding lag behind the harsh reality of what happens in society currently. Alright. We have some high profile examples of people and women who've spoken out particular issues that have occurred to them, some very high profile if we're talking about Parliament House or we are talking about women in positions of power. But then we have to acknowledge that the reality is that this affects all groups of women and some are very disempowered. And we're hearing more, for example now about the missing and murdered indigenous women. And this has been recognised around the world, places like Canada have had a very good discussion about that. We are probably only just beginning and we don't even keep data

Sabin Fernbacher (10:23):

And we might be able to touch on some of those more specific issues or population groups. Also in the second podcast too, we were talking about maybe that will be a good theme for that. Absolutely. There are some people that have more resources or access to support. Not that it's not distressing for anybody who experiences this. So if we come back to the kind of context, Louis, that we're talking about for this podcast or for our conversation today, family violence in the context of mental health and also mental health services. And as you say, systems often lag behind in getting better or being good at supporting people. Or in this case, if we talk about women, what do you see as some of the complexities around family violence and mental health and the systems in supporting providing good support for let's say women who've experienced family violence as well as mental health challenges?

Louise Newman (11:13):

Yes. Look, it's very complex and there are disagreements and discussions that go on about terminology. There are some obvious points to be made about not wanting to pathologize, if you want to use that word or assume that every woman who finds herself in a dangerous or violent situation where she might be attacked or harmed is somehow complicit with that, particularly if she's a woman who might well have had preexisting mental health issues. It really brings up this issue that we are still thinking about the chicken and egg question if you like. Does the experience of victimisation and terrible forms of domestic violence and family violence affect mental health? From my perspective, I do work clinically in the area, yes, of course it can. That's not to say that the victim survivor herself has been complicit in any way, but that argument can be used and it can even be used by perpetrators to say, well, look what she made me do.

(12:25):

Blaming women for their own abuse, which of course is totally unacceptable. And as a way of taking no responsibility, the issue is complex largely because of psychiatric terminology. We do see in clinical

practise within mental health, sometimes women who've had multiple experiences of really dysfunctional relationships in which they experience a variety of forms of abuse. And there has been a tradition in some areas of mental health theories to sort of talk about that. Sometimes it's described as quotes, learned helplessness that women in those situations might very much have lost their capacity to struggle or sometimes even to recognise risk. Now that certainly can happen for some women. Being entrapped in a violent and terrible relationship is a reality. I see. And treat some women who might've been in appalling relational situations. For one woman I see 10 years, sometimes it's the reality of leaving is too hard.

(13:44):

We don't support women in that. It's dangerous, all the reasons that we are familiar with. But there is also that the emotional impact of terrible low self-esteem, a feeling of just, well, this is my lot. I just have to accept it. Not having adequate support to actually do the leaving and total demoralisation. Women in that situation are depressed, can be very anxious and traumatised and fall into sometimes that wish of appeasing the perpetrator. And I will talk to women about this is not for you to change and it's not, the onus is not on you to change yourself to stop the violence or abuse, but these are very strong narratives that women tell themselves.

Sabin Fernbacher (14:36):

And also as you touch on so many of the things that you've just said, Louise, making the decision to leave or separate is we know incredibly difficult, a lot of women end up homeless, lose money, lose income, have to move long distances, unstable housing, because that's kind of what the system does. So many reasons why it's hard to leave if somebody makes that decision. But I also want to come back to that terminology. I'm so glad you erased it, the learned helplessness. And I've just written it down with a quotation mark because it's also, again, stigmatising women, isn't it? Rather than understanding someone's situation and understanding the risk factors. And you mentioned that as well. We know for example, from numerous research studies that the time when a woman is getting ready to leave might say that she's going to separate or has left, is sadly.

(15:28):

And a warning this is distressing is the time when women are killed and sometimes women are children are killed. It's research evidence around the world shows that the time after leaving is the most precarious time. So women often instinctively also know when you were saying appealing or appeasing to the person using violence. When we turn that around and trauma-informed care certainly teaches us that, doesn't it? It's a survival technique. It's women often know how to manage. And of course it's not their responsibility to try and change the person who uses violence behaviour because they might love the person, but they want the behaviour to stop or to change. And that goes from many, many people.

Louise Newman (16:06):

Well, that in itself is a really complex issue. Loving someone who's dangerous and destructive and aggressive actually mean. And if you're working clinically with women who've been in these situations, that's something that really puzzles them and troubles them even if they've left the relationship some time ago, needing to try and understand what was I looking for with this person who proved to be really dysfunctional and just not a nice person right from the beginning. And yet there's often a hope that maybe the person will improve over time. Now sadly, what we know is that many don't improve over

time. Danger can increase. And then if a woman says, well, look, I'm not putting up with this anymore. I think I need to leave, danger really begins. So I see women who have been stalked by former partners in a very dangerous way, and that's made their lives unbearable.

(17:10):

They can't leave their premises, they're scared, they're under police surveillance. And yet we know that our systems have responding to that. Our legal processes, rates of charging perpetrators with stalking are actually very low. And yet it is such a predictively dangerous behaviour and it tends to escalate. That's telling us something about the psychology of perpetrators. They cannot tolerate the relationship being ended. And then sometimes women, rather than put up well, that will say, well, okay, I'll come back if you change the behaviour, which is a reasonable request, but the chances of that actually happening are low. So it's fraught with danger. Now that's not in itself a mental health problem, but what it is telling us about really is the impacts of living in these really disturbing relationships on a woman's feelings of self-worth her self-esteem. Yes, she's in survival mode, which is very appropriate.

(18:14):

And particularly if there are children involved, she feels responsible for trying to help them because we know that in many violent families, children not only observe violence, but they're direct victims usually of physical assault, occasionally sexual assault in up to 50% of cases in some studies. So that's hugely significant. And the guilt that women can experience when they feel trapped and unable to escape, and then they start to feel unable to protect their own children. So that in itself contributes to feelings of depression, chronic anxiety, all of which do become severe, really disabling. There's nothing like being in a state of high stress and feeling stuck to bring on depression and not be able to think your way through a situation. And that's where mental health services obviously have a role.

Sabin Fernbacher (19:12):

Yes, absolutely. And you were touching on earlier, Louise, about the chicken and egg of what comes first. And sometimes I think in the way we can support women and children, sometimes I say it kind of does matter. The reality is somebody's experienced this and is also experiencing depression, anxiety or any other type of mental illness, diagnosed or not, how can we best support someone? And we might in a moment move on to thinking about that a little bit in the mental health services context. I wanted to offer a story a woman shared in this context. It was around cursive control and how slowly, slowly her partner started to control her. And she lived within that relationship for 20 years and he was really subtle and slowly and first he was, oh, you don't need to do that. I I'll do that. Oh no, you don't need to go out to work.

(19:59):

I earn enough money. And more and more, he slowly over time isolated her from family, from workplace and isolation, social isolation, which is also kind of a form of entrapment, isn't it, is so often part of in particular intimate partner violence, maybe not so often about other forms of family violence from relatives. And she said that became her new normal. She was so used to being so controlled that she really lost that sense of self and that confidence to go out and find a job to go out. And eventually she did, but she really needed some really good solid support including mental health support because of course over time they did impact. And we also know from studies in the other area of family violence services, for example, that often when women first get in contact or are accommodated in a family violence refuge, that depression and anxiety rate really high and that many women could, they don't

necessarily get a clinical diagnosis, but anxiety as we would understand is really high. Often that really subsides over time once they become safer, but for some it doesn't. So there is that immediate and sometimes longer term impact as well, doesn't it?

Louise Newman (21:16):

Yeah, no, I agree. I think there are two points to make. Obviously there's a spectrum of mental health issues that confront women in all these situations. The long term survivors can carry a huge burden of PTSD, if we want to call it that. So post-traumatic symptoms, high levels of anxiety, demoralisation and depression from a mental health point of view, we do see sometimes women who are really quite overwhelmed by their depressive symptoms in particular and are virtually not in a position to make decisions or think their mood is low, they can be suicidal, the situation seems hopeless. Some are self-harming, some are abusing substances or alcohol, anything to sort of deal with the pain of the situation. They find themselves in some need more support for those symptoms before you can address the really important issues which are about recovery and thinking about what an independent and sense of more stable identity and being able to have a life independent of everything that they've been in actually means.

(22:34):

So mental health services have a role, not the whole role. There's a whole range of other systems that need to be involved in this, as we know ranging from legal supports right through to housing and some of the basics. So there's a lot of things that need to happen, but to me, the fact that women suffer mental health issues as a result of these terrible situations is not at all surprising. I think what troubles me is that within mental health services, this is my second point, there's sometimes been a failure to explore the reality of trauma and abuse in the lives of women and children presenting with a whole range of issues and not asking the questions. We tend to focus to use the old saying on the what's wrong with you question rather than what's happened to you. So a trauma focused way of thinking about women's mental health acknowledges 0.1, the high rates of abuse and maltreatment in the lives of women and girls, that is socially sanctioned, pretty epidemic at the moment, or it's a pandemic actually, if we think about the global situation.

(23:48):

And the other thing that happens is we as speaking for mental health services have sometimes not bothered to explore these issues, particularly in women who are suffering from sometimes significant mental disorder or even mental illness who we know statistically are often victims because it's in a way for some perpetrators easier to manipulate, exploit control and then abuse women whether they've got an illness such as a psychotic illness or whatever sort, or they have drug and alcohol problems and so on. Now, I would use the term vulnerability to describe those women as being, or the other terminology that we could use, but it's not really capturing it, is that they have risk factors, risk factors for exploitation, or they're living in dangerous communities where there's community breakdown and other problems. And we can talk about this maybe in the second podcast again, but I think they're important.

(24:55):

That's not to say that we are attribute all the violence and abuse to the vulnerability, but we have to acknowledge it. And within mental health services, the other point that I would make is that we have sometimes ignored the safety of women within those services. Now I've been involved in some service reviews where they've been concerns about exploitative and damaging and sexual assaultive behaviour

going against women in a mental health facility. I mean, these are very disturbing and we've had reviews of this obviously in several jurisdictions. This is a real issue and that's led to a lot of the discussion about women's only and safe spaces for women within our mental health facilities. Again, it's a matter of just acknowledging the different ways that the abuse of women can manifest itself.

Sabin Fernbacher (25:53):

Absolutely. You've just touched on a number of really important points, and I might just pull two of them out and if I can maybe just add on a little bit to what you were saying in terms of that context of family violence and mental health or mental illness and how services can better support women. And part of that, what women with a mental illness also experience is abuse or using their mental health status against them as part of the perpetration of family violence. And I just want to give a couple of examples and then we could maybe think about how mental health services or anybody who works in this space. Again, this is from stories from women survivors, but also from some research studies. And you and I have had conversations about this and you've said you see this in practise all the time. And when I was working in clinical mental health services, I was supporting staff to understand some of this as well.

(26:48):

So for example, a partner might be using a woman's mental health status against her by trying to control when she takes the medication. An example is the woman needs to take medication in the evening. He makes sure he forces her to take it at five o'clock by seven o'clock. She's so tired, she needs to go to bed. Controlling her life or when she takes medication or coming to absolutely every appointment being seen or experienced by some people is, oh, this is a really supportive partner, but actually he's controlling the space down to controlling what is said in this space because he doesn't want her to talk to the psychiatrist or the mental health clinician or the GP about what's happening, such as using medication control. But other things as well. We know that police have turned up at the doorstep. I stay in the binary, him, her male partner had just abused her emotionally, physically, psychologically, in whatever way she's distressed.

(27:51):

He opens the door and says to the police, look, she's got a mental illness. Look at her, look at her dishevelled. She doesn't even know how to look after kids. Badmouthing her as a bad mother using her mental illness against her. For example, we know of examples where the woman might come home and say, how come you changed the furniture around in the lounge room? And he says, I didn't do anything. What are you talking about? I think you might be coming unwell. You're imagining you're seeing things, you're delusional. So playing into someone's psychosis if that's what she's experiencing. Many other ways to use it. Also, for example, threatening to talk about someone's mental health status at their work or outing them about their mental illness. So I hope that you can hear some of those ways of how that is being used. And sometimes people have found it difficult to understand that that's actually what's happening rather than listening to the woman when she says, look, these are the things that are happening or trying to talk about that with a mental health practitioner. Louise, what are some of the things that we could think of how people working in that space could get better at supporting and listening to women in?

Louise Newman (29:08):

Look its a real skill, isn't it? And I think it takes some reflection on how are we actually going to create safe spaces where women can speak in private and sometimes look in maternity services where I've worked for some time, we go to all sorts of lengths to keep controlling. If we have concerns that a man there is controlling or abusive, the one thing they don't want to hang around for are pelvic examinations and so on. It's secret women's business. So we use that. We say, well, look, we have to examine your wife now and so on, and we get to discuss some of the issues. Without that, we're not being adequate, I don't think, in getting the information. So we need safe spaces. We need the information. There's also, I think working out for ourselves what our focus is, who is our priority if we suspect or have evidence of this sort of abuse going on?

(30:05):

Some services make a distinction between prioritising a women's mental health focus and referring alleged perpetrators or men who need their own support elsewhere. So in a women's hospital for example, we would not treat alleged perpetrators. That's not to say we wouldn't offer them access or give some suggestions about where they could get help in mental health. I think the same should apply where there are high levels of reasonable clinical suspicion or other evidence that the relationship that someone's involved in is directly contributing to their distress and mental health issues, and that the perpetrator is presenting a narrative of control. So just an example of couple I've seen recently where the man apprehended violence orders, they're in no contact and I only zoom perpetrators. I don't see them in person wonder. He said, well, I'm going to tell you about the crazy ex-wife quote. He was a very violent man himself with I had his police records, very violent behaviour.

(31:16):

I was very glad I didn't get to see him in person because he's a ginormous steroid abusing bodybuilder with a long history of drug issues, very high risk. He had actually been jailed for his violence, which he denied. He denied it because he said she was the crazy one and she provoked him. She knew how to intimidating and belittle him. So the narrative was all about his feelings that she provoked him, this is what happened. Yes, he shouldn't have taken so much ice and steroids and so on. Absolutely no responsibility and a whole narrative of blaming this woman. And I think the point to remember is that this is a very common story that goes around, and it's partly because it's got cultural and historical legitimacy. If you want to think about the history of how we've seen women's mental health since the beginning of time, apparently, and particularly in the rise of contemporary mental health practise has been that women are somehow more vulnerable to mental illness.

(32:24):

That's a biological given. Women are ruled by hormones from the time of the ancient Greeks and the wandering womb. We've had these stories, which are remarkable, very interesting to look at the history of this because many ways, although we like to think of ourselves as very enlightened in terms of understanding women's emotional life and mental health issues, we really haven't come that far. We still focus on innate, intrinsic biological and mental weakness. So there is a way in which contemporary offenders play into that and are very quick to use whatever psychiatric diagnosis they come across. Crazy was what the man I interviewed said, but then he went on to say that he knew about this thing called borderline personality disorder, which is another one of those controversial trauma related labels. And he knew that those people were unstable, that it was mainly women. So he'd done a little bit of work around that and was prepared to use that.

(33:33):

So these stories, they're often in courts. This man was facing a jail term, which was a positive thing, and they're very common in what we see now. The impact of that on survivors is huge to be consistently told often for years that, and this is the gaslighting notion that you are mad, but what we need to remember in mental health and what we need to understand better are the long-term implications of being in that situation, regardless of whether someone has experiences of stress related, trauma related mental health issues, which well, they might, but being told that you're actually, and like the word that the man I described used crazy or insane as an insult, let alone if someone does have a medication dependent, more severe illness and perpetrators are quite capable of overmedicating partners who they wish to control and blocking women's access to mental health supports and services. And some women are in situations where that's a chronic pattern. Men taking women to psychiatrists and saying, look, she's clearly having a relapse of her illness and should go under the Mental health act and so on. If we don't take the time as clinicians to literally talk to that woman about her experiences and what's happening, we might well miss a situation. So I think that's the practical implication of it.

Sabin Fernbacher (35:12):

Yeah, absolutely. And maybe in our second episode, we were going to touch on trauma informed care, but we are coming to the end of this podcast. I suppose, again, what you've just touched on, it's educating ourselves, attending training, understanding that the area of family violence and connection to mental health and getting as good as we can, as best as we can to find words and language and hopefully listeners work in an organisation that organisations also have good structures, good policies, and good support around how to ask some of those questions. Because around Australia and beyond, there's been a lot of work being done about how to sensitively ask questions around that, even if somebody doesn't upfront talk about it. But in particular, when we can see signs, some of those things that we've touched on, trauma-informed care, for example, you touched on earlier, someone when self-medicate and we know childhood trauma survivors, but also survivors of family violence, sometimes having a drink and sometimes having a number of drinks, it just numbs the feelings.

(36:17):

And we can understand that that is, again, a survival mechanism. Sometimes, sadly, it kind of backfires and becomes unhealthy, but initially it's about getting through some awful memories, for example, or medication with prescription medication. So we might come to a close for today. Louise, thank you so much for joining me in this. You've been listening to me, Sabin, Fernbacher and Louise Newman. We've covered a lot of ground, so we outlined a little bit the issues around family violence and mental health, and we've talked a bit around some of the issues that might surface for you in your practise, and we've also talked about gaslighting within that context, and we might explore some more about that in our next podcast and might also take a look at how family violence impacts some population groups that might experience some additional challenges as well. That episode will be released Wednesday fortnight.

(37:14):

If you want to learn more about Louise or myself, or if you want access to the resources we've referred to in this podcast or that we've drawn on, you can go to the landing page of this episode and follow the hyperlinks, MHPN values your feedback, and on the landing page, you'll find a link to a feedback survey. Please follow those and let us know whether you found this episode helpful. Let us know what you didn't find helpful, provide comments or suggestions also about how MHPN can better meet your needs.

Thank you for your commitment listeners to engaging in interdisciplinary and person-centered mental health care. It's goodbye from me. Sabine, goodbye from me, Louise. Thank you.

Host (37:58):

Visit mhpn.org.au to find out more about our online professional programme, including podcasts, webinars, as well as our face-to-face interdisciplinary mental health networks across Australia.