Introduction

Domestic violence (DV) victimization is a significant trauma that can result in both short-term and long-term emotional and mental health problems. DV survivors (also referred to as survivors of intimate partner violence) may frequently suffer from psychological symptoms associated with stress and trauma (O’Brien & Macy, 2016). A cohort study in the UK found that women who experienced intimate partner violence (IPV) had 2.62 times the odds of mental illness, including depression and anxiety, than unexposed women (Chandan et al., 2019). In addition, a cross-sectional survey showed that the posttraumatic stress disorder (PTSD) scores for the majority of DV survivors were above the clinical threshold (i.e., they would likely be diagnosable in a treatment setting), and that their depression and anxiety levels were also close to clinical thresholds (Ferrari et al., 2016).

Among survivors of DV, emotional health problems and mental health disorders can co-occur and overlap (e.g., a survivor might struggle with both depression and PTSD; Macy, Jones, Graham, & Roach, 2018). Thus, this entire set of emotion health problems may be described as “trauma-related mental health symptoms and illnesses,” referring to the comorbidity of multiple mental disorders often associated with the experience of trauma from DV victimization (Macy, Jones et al., 2018, p. 36). Researchers have reported that the severity of such psychological symptoms is often closely associated with survivors’ individual characteristics, relational situations, and sociocultural context (Goodman, Smyth, Borjes, & Singer, 2009; Sasseville, Maurice, Montminy, Hassan, & St-Pierre, 2020). That is, the disadvantaged and oppressive context in which some survivors live (e.g., having few economic resources, previous exposure to violence, racism, and other forms of oppression) can contribute to and/or exacerbate survivors’ emotional and mental health issues, as well as impede their help-seeking efforts for DV (Goodman et al., 2009). Accordingly, survivors’ mental health problems should be assessed and addressed within the context of the abusive relationship, as well as in the other personal, situational, and sociocultural contexts which compose and influence women’s coping with the trauma of DV.

For all these reasons, this chapter first aims to overview the major emotional and mental health problems faced by DV survivors, attending specifically to the problems of depression, posttraumatic stress disorder (PTSD), suicide intentions, and substance abuse. The chapter will then discuss mental health service delivery settings. Finally, the chapter will present key
intervention approaches for DV survivors’ emotional and mental health problems, including cognitive behaviour therapy (CBT), mindfulness interventions, advocacy, and trauma-informed substance abuse treatments. Throughout, the chapter will attend to the evidence on which these topics and issues are based, including the limits of the research, and note on how cultural context intersects with these issues, as well as discuss the key challenges for the DV field concerning how best to address survivors’ emotional and mental health (Goodman et al., 2009).

**Discussion and analysis**

**Major emotional and mental health problems among domestic violence survivors**

**Depression**

Depression is characterized by persistent sadness, loss of interest in activities once enjoyed, and lethargy that impairs the individual’s ability to function in both social and work settings (WHO, 2019). The findings of a meta-analysis suggest that DV survivors have 2 to 3 times the odds of incident depressive disorder and 1.5 to 2 times the odds of incident elevated depressive symptoms and postpartum depression in comparison with women who have not experienced DV (Devries et al., 2013). The degree of depression is often closely associated with sexual violence experiences, previous trauma, pregnancy and childbearing, and living situations, such as poverty. For example, experiencing sexual violence from an intimate partner increases both the probability and the severity of depressive symptoms (Chen, Rovi, Vega, Jacobs, & Johnson, 2009; Dillon, Hussain, Loxton, & Rahman, 2013; Garcia, Stoever, Wang, & Yim, 2019). Prior traumas and pregnancy and childbearing experiences also exacerbate such psychological difficulties as depression in women facing DV (Kendall-Tackett, 2007; Ludermir, Lewis, Valongueiro, de Araújo, & Araya, 2010; Warshaw, Sullivan, & Rivera, 2013; Jordan, Nietzel, & Walker, 2004).

Research also indicates that the relationship between violence victimization and depression appears to be bidirectional (Devries et al., 2013). Women who experience violence victimization are more prone to depressive symptoms; and conversely, women with existing depressive symptoms are more likely to experience subsequent DV. There are various possible explanations for this relationship. For instance, women struggling with depression may be less sensitive to signals of incipient partner abuse, and/or they may be less likely to seek help because depression might dampen their capacities toward active coping (Devries et al., 2013; Iverson et al., 2013; White & Satyen, 2015). Moreover, the relationship between depression and re-victimization is also likely potentiated by women’s situational context, with challenges such as discrimination and racism, poverty, and other oppressions also playing roles in the continuation of depression and violence. Regardless of the causal factor, unresolved mental disorders may play a role in DV re-victimization.

**Posttraumatic stress disorder (PTSD)**

PTSD shows four core symptoms: “intrusive recollections of the event, avoidance of reminders of the event, negative alterations in cognition or mood, and alterations in physiological arousal and reactivity” (Wortmann, Larson, Lubin, Jordan, & Litz, 2015, p. 192). Along with depression, PTSD has been identified as one of the most prevalent mental health issues among DV survivors (Allen, 2013). In cross-sectional studies, around 25–50% of the survivor women showed moderate to severe PTSD symptoms (Coker, Weston, Creson, Justice, & Blakeney,
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2005; Woods, 2000). Researchers have reported that chronic and severe DV victimization (Pill, Day, & Mildred, 2017), multiple victimization experiences, including sexual abuse (Coker et al., 2005), as well as recent partner abuse and recent interpersonal trauma (Khadra, Wehbe, Fiola, Skaff, & Nehme, 2015) all increase the risk of PTSD symptoms. Moreover, PTSD symptoms among violence survivors might differ from symptoms resulting from a one-time traumatic event. Researchers have noted that multiple or chronic traumatic events in which the perpetrator and receiver of the violent victimization have ongoing contact are associated with more complicated and multifaceted PTSD symptoms than symptoms resulting from a one-time traumatic event (Pill et al., 2017).

**Suicide intention**

Suicide intention is another serious mental health issue often associated with DV victimization. One systematic review found that, with only one exception, all of the studies showed a strong and consistent association between intimate partner abuse and suicidality (McLaughlin, O’Carroll, & O’Connor, 2012). Not surprisingly, the relationship between DV victimization and suicidality can be influenced by other mental health problems. For example, a cross-sectional study showed that the presence of PTSD and depression mediated the relationship between sexual abuse and suicidal ideation among sheltered women (Weaver et al., 2007). In a study of African American survivors’ suicidality, Kaslow and colleagues (1998) found that psychological distress, hopelessness, and drug use were risk factors that increased the women’s suicidality; and social support was a protective factor that decreased their risk.

Notably, some research shows that abused women who seek shelter and abused women who are pregnant should perhaps be considered at heightened risk of suicidal ideation. As an example, Martin and colleagues (2007) reported that abused women were more likely than non-abused women to have attempted suicide while pregnant. Likewise, one-third of shelter-seeking women reported suicidal ideation or suicide attempts (Golding, 1999). These findings may suggest that for abused women in specific circumstances such as pregnancy and homelessness, seeking safety comes with practical difficulties (e.g., finding employment and housing, and engaging in healthcare and legal processes) that increase distress, which may in turn, increase vulnerability to suicidal ideation.

**Substance abuse**

Women who experience DV victimization may also be more likely to use drugs or alcohol to cope with their trauma and distress (Macy & Goodbourn, 2012). Research has shown that the rates of substance problems are five times higher among women victimized by DV than among non-exposed women (Logan, Walker, Cole, & Leukefeld, 2002). However, a meta-analysis of longitudinal studies found a bidirectional relationship between substance abuse and victimization (Devries et al., 2013). In particular, when substance abuse co-occurs with other problems such as depression or PTSD, women may be less able to detect warning signs of emerging violence and may be less likely to access safety resources (Iverson et al., 2013; Weaver, Gilbert, El-Bassel, Resnick, & Nouri, 2015). Furthermore, alcohol use among women is likely to be confounded by their partners’ alcohol use, as women and men may drink together; and men’s alcohol use is strongly linked with DV perpetration (Devries et al., 2013). Overall, women who use drugs and suffer from violent victimization are more likely to continue using drugs and to have more substance abuse relapses (Weaver et al., 2015).
Intersectionality

As discussed, DV survivors’ individual, relational, and sociocultural circumstances can intensify their mental health problems. Research has indicated that racially marginalized and socio-economically disadvantaged women experiences stress, powerlessness, and social isolation in cumulative contexts; and that this vulnerability produces and exacerbates depression, PTSD, and other emotional difficulties (Goodman et al., 2009; Sasseville et al., 2020). For example, abused women in poverty are disadvantaged not only by the traumas of violence and subsequent feelings of powerlessness, but also by the scarcity of resources that might be used to cope with these conditions (Goodman et al., 2009). Immigrant women are at especially heightened risk of experiencing depressive symptoms (White & Satyen, 2015). The stress of acculturation, including language barriers and lack of social support, might place significant additional stress on relationships that already involve DV victimization (White & Satyen, 2015). It also should be noted that such situations and contexts may lead to disparities in the services available for DV intervention and safety. In turn, such disparities may lead to re-victimization, as well as further mental health problems.

Approaches and challenges to service provision for violence survivors’ mental health

DV survivors struggling with mental health problems may be reluctant to seek help or utilize relevant services due to feelings of shame, fear, isolation, and distrust of others. Thus, a survivor-centred, trauma-focused approach is needed to identify women struggling with DV and to deliver appropriate services. This section is an overview of service settings for survivors’ safety and mental health, and a discussion of challenges to such service delivery.

Community domestic violence (DV) service setting

In general and in some parts of the world, community-based organizations (CBO) and non-governmental organizations (NGO) DV agencies are on the frontlines of delivering mental health and safety services to violence survivors (Macy, Martin, Nwabuzor Ogbonnaya, & Rizo, 2018). Although such CBOs and NGOs tend to offer a range of services to survivors and their families, DV agencies generally provide services such as 24-hour crisis lines and emergency response, counselling, support groups, court and legal advocacy, shelter services, as well as referrals to other services in their communities (Van Deinse, Wilson, Macy, & Cuddeback, 2019). In particular, individual/group counselling and support group services that are delivered in such agencies can provide mental health care and emotional support for violence survivors. Nonetheless, counselling provided by DV agencies typically focuses on supportive assistance and help, which does not necessarily include mental health treatment and which may be delivered by staff or volunteers without mental health expertise (Macy, Giattina, Montijo, & Ermentrout, 2010). Such an approach is often associated with the historical development of DV response services, which tended to have community-based, grassroots origins emphasizing social justice and empowerment (Macy et al., 2010; Macy, Rizo, Johns, & Ermentrout, 2013).

Service Barriers

DV agency leaders have often reported that their staff lack mental health expertise, which in turn, prohibits counselling services that include a focus on women’s mental health, especially
when women are struggling with serious mental illnesses such as major depression (Macy et al., 2010; Van Deinse et al., 2019). Even though DV agency directors recognize the benefits of offering mental health services on site (Macy et al., 2010), they are often unable to offer such services due to lack of funding for mental health professionals, inadequate staffing, and insufficient training for employees (Macy et al., 2010; Mengo, Beaujolais, Kulow, Ramirez, Brown, & Nemeth, 2020). These agencies gaps and needs also presents challenges in helping violence survivors with substance abuse. For instance, DV agencies do not always allow violence survivors with substance problems to access their shelter services both to ensure other survivors’ safety and because they lack agency staff to address substance abuse issues (Van Deinse et al., 2019). As violence survivors might use alcohol or drugs to cope with distress or at the coercion of their partners (Weaver et al., 2015), such policies might prohibit survivors with urgent needs from accessing safety services (Van Deinse et al., 2019). Given these challenges, staff at DV agencies may refer violence survivors with mental health problems to local mental health and substance abuse agencies in their communities, if such services are available.

**Mental health setting**

The mental health system has a part to play in the prevention of DV and women’s re-victimization through identifying violence survivors, providing clinical care for mental illness, and coordinating advocacy with other services sectors (e.g., child care, housing and shelter, and legal advocacy; García-Moreno et al., 2015). As discussed earlier, mental health professionals encounter violence survivors not only through referral systems but also through diagnosis and self-disclosure of DV among their patients. For example, a survey of mental health clients in London discovered that 70% of female service recipients had been victims of DV and abuse as adults (Khalifeh et al., 2015). Because mental health professionals frequently encounter violence survivors, international organizations such as the World Health Organization (WHO) recommend that mental health professionals encourage disclosure of abuse as part of routine clinical assessments and to provide appropriate referrals and treatment in the context of violence and trauma (Oram, Khalifeh, & Howard, 2016).

**Service Barriers**

Research indicates that mental health agencies face individual and systemic barriers in providing services to violence survivors, including a scarcity of services overall, few qualified mental health professionals, and high staff turnover (García-Moreno et al., 2015). Globally, the availability of mental health services is highly variable with some countries and communities offering mental health care freely, other countries offering such services in a way that is personally costly for those seeking care, and with some countries and communities not able to offer mental health care at all to anyone (Alegría et al., 2000; Ngui, Khasakhala, Ndetei, & Roberts, 2010). Even when such services are available, violence survivors referred to mental health settings often experience long wait times before intake and/or changes in counsellors. In this context, García-Moreno and colleagues (2015) suggest that referral to mental health agencies might not always be effective, especially in low-income and middle-income countries that lack an adequate workforce of mental health professionals. In addition, it is worth noting here that even when both DV safety services and mental health services are available in a given community, there have historically been and may continue to be tensions between these two service sectors given their significantly different treatment and services approaches and philosophies (Chandan et al., 2019; Van Deinse et al., 2019).
Another challenge at the intersection of DV and mental health is that mental health professionals often lack trauma-informed practice training and guidance. This lack, in turn, results in mental health professionals being unable to identify violence survivors or provide trauma-focused services to survivors in consistent and high-quality ways (Oram et al., 2016). As violence survivors might tend not to seek outside help for their abuse and trauma, professional identification of DV can be a significant early step in providing help and services. In addition, mental health professionals often respond primarily with individual-focused psychotherapeutic solutions designed to help victims and may miss the particular impact of DV on survivors’ mental health and well-being (Goodman & Epstein, 2008). Likewise, pathologizing survivors’ mental illness obscures understanding of inter-correlated trauma symptoms and hampers implementation of comprehensive treatments (Oram et al., 2016).

Future directions for service delivery

As discussed, organizational service gaps and service providers’ limited skills might be barriers to providing timely, effective mental health services. Thus, dedicated training to ensure meaningful and safe responses is necessary. Many researchers and practitioners have emphasized the importance of trauma-informed care training for DV agency staff and mental health professionals (Macy et al., 2010; García-Moreno et al., 2015; Mengo et al., 2020). As a specific approach, DV agencies and mental health settings’ inclusion of substance abuse providers could implement cross-training guided by trauma-informed principles (Macy & Goodbourn, 2012; Van Deinse et al., 2019). This cross-training could focus on building service providers’ understanding of the interrelationship between trauma, DV, mental health, substance use, and other comorbid problems and could foster a mental health/substance abuse-focused counselling approach (Macy & Goodbourn, 2012; Van Deinse et al., 2019).

In addition, poor service coordination between mental health providers and DV agencies creates a critical gap in mental health service delivery (Mengo et al., 2020). Thus, it is essential to reduce service gaps between DV agencies, mental health care, and substance abuse treatment settings. As one strategy, multisector service providers could create protocols for referral networks and systems and other collaborative service provision (Mengo et al., 2020). Protocols and guidelines can support multisector providers by letting them know what actions to take as well as what services on which to collaborate (Mengo et al., 2020). For example, such service protocols should include clear guidance on specific referral processes, how best to attend to survivors’ service priorities and needs, how best to monitor survivors’ progress, as well as how best to assess survivors’ service outcomes and completion.

Key intervention approaches for survivors’ emotional and mental health

This section will introduce four major intervention approaches for improving survivors’ emotional and mental health, as well as review empirical evidence for the effectiveness of these interventions. It should be noted here that these interventions are not always distinct approaches. Rather, these interventions are often interdependent and overlapping in their theoretical grounding, in how they have been investigated in research studies, and in how they are implemented in practice.

Cognitive behaviour therapy

Cognitive behaviour therapy (CBT) is a treatment that has been widely used and validated across many clinical settings among violence survivors with mental health disorders – in
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particular, PTSD. The central principle of CBT is that DV survivors’ cognitions, the process by which individuals understand incoming information, determines their emotions and behaviours. Thus, CBT posits that modifying women’s cognitions will lead them to desired changes in their corresponding emotions and behaviour (Macy, 2006). CBT includes a wide range of individual and group interventions that use cognitive and behavioural components such as exposure therapy, motivational interviewing, and/or problem-solving techniques which focus on positively changing existing unhelpful cognition (Tirado-Muñoz, Gilchrist, Farré, Hegarty, & Torrens, 2014).

Effectiveness

CBT has generally shown benefits for violence survivors’ mental health. For example, Kar (2011) reviewed 31 randomized control trials to evaluate the effectiveness of CBT in treating patients with PTSD. The review suggested that CBT methods such as exposure therapy are effective treatments for both acute and chronic PTSD, having both short-term and long-term benefits. The review also suggested that CBT is effective for clients dealing with comorbidity of PTSD and other severe mental illness. As for the effectiveness of specific types of CBT, Diehle and colleagues (2014) conducted a meta-analysis to determine which CBT methods are most effective in reducing trauma-related cognition among people with PTSD symptoms, including survivors of DV. Using 16 randomized controlled trial studies, the author found that trauma-focused CBT interventions led to the greatest reduction in PTSD and trauma-related cognitions.

Despite such promising findings, readers are encouraged to keep in mind the limits of this body of research. Although review research has found positive effects of CBT for violence survivors, the articles used for these reviews were limited in some key ways (Diehle, Schmitt, Daams, Boer, & Lindauer, 2014; Kar, 2011). For example, CBT interventions are generally short term. In addition, the majority of studies reviewed involved racially homogeneous samples of mostly white women (Schmidt, 2014) even though some studies found validated findings of CBT for culturally diverse populations (e.g., Kubany et al., 2004).

Further considerations

Careful consideration is necessary in applying CBT to DV. For example, CBT interventions are most often recommended for women who are no longer experiencing violence and may not be as helpful for women who are still struggling with violent victimization and needing to secure their safety (Tirado-Muñoz et al., 2014). In addition, because CBT emphasizes individuals’ thoughts, it focuses on changing beliefs – a fact which might conflict with individuals’ cultural and/or personal values. Therefore, practitioners should understand patients’ cultural values and how they relate to survivors’ cognitions and emotions before undertaking CBT.

Mindfulness interventions

Mindfulness-based interventions include meditation, mindfulness movement such as yoga, mantras repeating a word or phrase to help in meditation, and individual body scans exploring physical sensations (Shapero, Greenberg, Pedrelli, de Jong, & Desbordes, 2018). These mindfulness practices commonly focus on self-regulation of attention to the present moment and acceptance of previous experiences (Dutton, Bermudez, Matas, Majid, & Myers, 2013; Shapero et al., 2018). Mindfulness-based practices can be used not only as solitary interventions, but
also as part of a broader treatment program (Niles et al., 2017). Even though mindfulness-based interventions are used frequently with CBT, they differ from CBT in that they focus not on changing cognitions, but rather on learning to experience thoughts as internal events which a violence survivor can accept or let go (Kahl, Winter, & Schweiger, 2012). Notably, mindfulness interventions show high retentions rates among clients and service users, and practitioners report that mindfulness intervention is suitable in cases where other treatments may be inappropriate (Lang et al., 2012).

**Effectiveness**

Although mindfulness-based interventions are a relatively newly researched therapeutic area, researchers have found promising results for survivors’ mental health. For example, Kelly and Garland (2016) examined the effectiveness of a trauma-informed, mindfulness intervention. Using a randomized study design, DV survivors attended an eight-week intervention involving meditation, gentle movement exercise, didactic lecture, and group discussion. Study findings showed significant decreases in PTSD, depression, and anxiety among the treatment group relative to the control group. However, this study was limited by a small sample, use of a waitlist control group, and lack of follow-up observations. More recently, Macy and colleagues (2018a) reviewed studies of the benefits of yoga for DV survivors. This review found that yoga may have generally positive and beneficial effects on survivors’ psychological symptoms, including depression, anxiety, and PTSD. However, Macy, Jones et al. (2018) noted that existing studies have serious, universal methodological issues, including a lack of randomization and control groups, lack of validated measurements, poor quality baseline data, and lack of long-term follow-up.

**Further considerations**

Mindfulness intervention should be used cautiously and with a consideration of individuals’ characteristics and unique situations. Research suggests that mindfulness skills focused on self-control may be unsuitable for individuals with severe trauma. As examples, meditation might cause flashback of abuse or exacerbate psychological disorders (Longacre, Silver-Highfield, Lama, & Grodin, 2012). In addition, mindfulness movement practices should also be used carefully, considering survivors’ ages, injuries, physical conditions, and prior trauma. For example, Macy, Jones et al. (2018) suggested that yoga should be used cautiously with pregnant women, older adults, and individuals with physical disabilities. Also, some yoga postures using a particular part of the body, such as the chest or groin areas, may cause discomfort or flashbacks for survivors of physical or sexual abuse (Longacre et al., 2012; Macy, Jones et al., 2018).

**Advocacy**

Advocacy programs, in the context of DV services, encompass a broad range of services designed to empower survivors by connecting them with community resources. Specific activities of advocacy services include support for safety planning, legal assistance, housing and financial advice, emergency housing, informal counselling, and ongoing support (WHO, 2013). DV survivors usually access these services through a staff member – often called an advocate – at a CBO and/or NGO violence service program (Macy, Giattina, Sangster, Crosby, & Montijo, 2009). Through advocacy interventions, victims receive not only support for their safety but also the emotional support of having the advocate’s companionship during stressful situations such as seeking legal remedies or testifying in court (Bell & Goodman, 2001). Advocacy may
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be especially critical to violence survivors who lack informal social support (e.g., family and friends), materials resources, and/or those who may face system barriers in advocating on their behalf (e.g., immigrant survivors, survivors with disabilities, survivors whose first language is not the language of the community in which they are living, youth who are survivors; Bell & Goodman, 2001).

Effectiveness

Two systematic review studies investigated the effectiveness of advocacy interventions (Rivas et al., 2016; Tirado-Munoz et al., 2014). Overall, the findings regarding advocacy programs and emotional health issues, including quality of life, depression, self-efficacy, and psychological distress, were mixed and inconclusive. These reviews noted that the primary studies that were reviewed had considerable heterogeneity in terms of the intensity of the advocacy offered (i.e., ranging from about 30 minutes to 80 hours), the delivery methods, and outcome measurements. Accordingly, it is difficult to evaluate the effectiveness of advocacy for survivors’ mental health, though the approach does appear to hold some promise for helping address survivors’ emotional health and trauma.

Further considerations

The effectiveness of advocacy as an intervention relies largely on positive, strong alliances and collaboration between advocates and violence survivors (Goodman, Fauci, Sullivan, DiGiavanni, & Wilson, 2016). However, research demonstrates that several factors may negatively influence the development and sustaining of these relationships. For example, ethnic minority groups might experience cultural misunderstanding with their advocates, which in turn, lead to significantly lower feelings of alliance (Goodman et al., 2016). Such findings point to the importance of culturally meaningful advocacy interventions that are tailored to survivors and communities.

Even though direct evidence of the effectiveness of advocacy programs on survivors’ emotional health is inconclusive and limited (Rivas et al., 2016; Tirado-Munoz et al., 2014), research argues that survivors’ emotional well-being is best established through a holistic approach to violence prevention that includes not only psychologically focused interventions, but also addresses survivors’ safety, child care, economic well-being, and housing, as examples (Pill et al., 2017). Accordingly, whether or not advocacy interventions are effective in improving violence survivors’ emotional and mental health on their own, these interventions appear essential in addressing violence survivors’ safety and well-being, which in turn, may also lead to survivors’ emotional well-being and mental health.

Trauma-informed substance abuse treatments

Research has found a high co-occurrence of mental health problems (e.g., depression, PTSD) and substance use disorders among trauma survivors. For example, individuals with a diagnosis of PTSD engage in treatment for substance use disorders at a rate five times higher than the general population (Atkins, 2014). Trauma is well known to commonly play a role in mental and substance use disorders, and thus should be systematically addressed across all prevention, treatment, and recovery settings (Macy & Goodbourn, 2012). Based on this need, a trauma-informed substance abuse service framework has been developed (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005; SAMHSA, 2011). Trauma-informed substance abuse services provide
therapies that are sensitive and responsive to the unique needs of trauma survivors, and they also offer trauma-specific interventions (Macy & Goodbourn, 2012; Reeves, 2015).

**Effectiveness**

Although there is limited evidence concerning trauma-informed substance treatment overall, existing research regarding this service framework are promising. For example, randomized controlled trials of the *Seeking Safety* program focusing on co-occurring issues of PTSD and substance abuse showed positive results (Najavits, 2007). A recent meta-analysis evaluating the effectiveness of *Seeking Safety* in reducing the severity of PTSD and co-occurring substance use symptoms also yielded promising findings. Among the 12 studies identified, findings showed medium effect sizes for *Seeking Safety* for decreasing symptoms of PTSD and modest effects for decreasing symptoms of substance use (Lenz, Henesy, & Callender, 2016). However, overall, research on the efficacy of these trauma-informed treatment is nascent. More work is needed to establish the efficacy of this service framework.

**Further considerations**

Even though trauma-informed substance abuse intervention is promising, this framework has not been widely used to deal with violence survivors’ substance abuse. Macy and Goodbourn (2012) provided several recommendations to promote increased collaboration among providers in both DV service settings and substance abuse treatment settings:

1) dedicated case management to facilitate referral and coordination; 2) interagency case consultation to coordinate services and treatment planning; 3) co-location of providers from collaborating agencies’ to promote service accessibility and foster interagency staff relationships; 4) assigning one staff member to act as an interagency liaison to facilitate collaborative efforts; and 5) developing working relationships at all agency levels.

In addition, a trauma-informed service approach underscores the importance of providing women with gender-specific substance abuse treatment, which attends to the pain and difficulties women have endured due to victimization, their role as parents, and the importance of their relationships with positive family members and intimates as critical components in their recovery from substance abuse (Elliott et al., 2005; SAMHSA, 2011).

**Future directions for intervention approach**

In general, the interventions presented in this chapter showed promise for addressing survivors’ emotional and mental health. However, the extant intervention studies reviewed here universally possess methodological limitations. Longitudinal studies with follow-up are lacking, and very little intervention research has addressed survivors’ co-occurring emotional and mental health problems. The available research also lacks studies that use randomization and comparison groups. Therefore, the findings of these studies might be confounded by various factors given that the research to date has not typically considered comparison group findings for baseline or follow-up. Small sample sizes limit the generalizability of the findings, and many of the intervention studies lack robust, validated measures. Therefore, this review underscores
the importance of additional, future research concerning interventions for violence survivors’ emotional and mental health, including research that uses rigorous study designs and includes longitudinal follow-up.

Also importantly, survivors’ history of abusive relationships, coping behaviours, and their emotional responses to victimization can be greatly influenced by their background, communities, and culture. However, existing studies suggest a lack of culturally informed approaches, as well as a lack of research examining the effectiveness of such approaches for violence survivors. Recently, a few studies have shown moderate effectiveness for culturally informed intervention (O’Brien & Macy, 2016; Kubany et al., 2004; Sokoloff & Dupont, 2005). However, the authors of this research emphasize that such approaches are still relatively new and require more evidence before being deemed effective. Accordingly, future practice and research efforts are strongly encouraged to develop and investigate approaches that are meaningful for and relevant to survivors’ background, cultural heritage, and community context. In addition, it should be pointed out that most of the research presented here focused on heterosexual women. Women are highly burdened by both DV victimization and mental health problems and thus should be a continued focus for both research and treatment. In addition, practitioners and researchers are also called to attend to these issues among LGBTQ+ violence survivors, as well as male violence survivors. Last but not least, practitioners and researchers are also strongly urged to collaborate with survivors, advocates, and community workers from diverse groups in order to facilitate the development of and research on intervention approaches (O’Brien & Macy, 2016).

Conclusions

This chapter explored the major emotional and mental health problems among DV survivors, specifically attending to the problems of depression, PTSD, suicide intentions, and substance abuse. The chapter then presented mental health service approaches and challenges to service provision, focusing on community-based DV agency settings and mental health settings. The chapter also presented key intervention approaches for DV survivors’ emotional and mental health problems, including CBT, mindfulness interventions, advocacy, and trauma-informed substance abuse treatments.

Research reviewed here suggests that survivors who are struggling with their emotional and mental health may be less likely to seek help and to access relevant resources and thus may be more likely to be re-victimized. Notably, some of the factors that may exacerbate DV survivors’ emotional and mental health problems (e.g., homelessness, lack of social support, poverty, pregnancy, and racism) may also present realistic challenges in accessing services. Such factors might be usefully considered social determinants of both DV and survivors’ mental health. For all these reasons, safety services, as well as mental health and substance abuse treatment programs, should consider how best to engage with and encourage violence survivors to participate in programming for their mental health and emotional well-being, for example by using dedicated outreach services and trauma-informed service approaches. Likewise, service providers should also be prepared to identify and address violent victimization among people who present for economic services, housing services, and prenatal care because survivors may seek services without readily identifying the violence that is occurring in their lives. In addition, practitioners across service sectors (i.e., DV safety services, mental health treatment and substance abuse treatment programs) should use a trauma-informed, holistic approach to identify and address violence survivors’ co-occurring emotional and mental health problems, as well as their safety and practical needs.
In sum, research strongly shows that many violence survivors struggle with serious emotional and mental health problems, especially survivors who have had prior experiences of violence victimization in their lives, as well as those who have experienced enduring and severe DV. Such emotional and mental health problems may be exacerbated by the challenges and realities of survivors’ lives (e.g., homelessness, poverty, and pregnancy), as well as the additional injustices that they may face (e.g., racism and discrimination). Encouragingly, there is growing attention to the intersection of DV victimization and survivors’ mental health. This increasing attention has led to the development of a number of intervention approaches that show promise for helping survivors with their emotional and mental health. Nonetheless, much of the intervention development and associated research is still only promising. Therefore, advocates, treatment providers, funders, and policymakers are strongly urged to continue and increase their attention to violence survivors’ mental health and emotional well-being.

Critical findings

- Domestic violence (DV) survivors often struggle with a comorbidity of emotional and mental health problems due to the trauma of victimization.
- Factors that exacerbate DV survivors’ mental health problems (e.g., homelessness, lack of social support, poverty, pregnancy, and racism) may also present realistic challenges in accessing services for safety and for mental health.
- Community DV service settings, mental health settings, and substance abuse settings are on the frontlines of delivering mental health and safety services to domestic violence survivors.
- Challenges in service delivery settings include a lack of collaboration among relevant service sectors and limited training in trauma-informed, culturally sensitive service provision. Effective collaborations require multidimensional strategies at the provider, agency, and policy levels.
- The intervention approaches reviewed here show promising results for improving survivors’ emotional and mental health. However, these intervention studies universally possess methodological limitations.
- Existing interventions often lack attention to or implementation of culturally informed approaches for violence survivors.

Implications for policy, practice, and research

Policy

- Policymakers should encourage DV agencies and mental health settings, including substance abuse treatment agencies, to implement cross-training guided by culturally sensitive, trauma-informed service.
- Policies should be enacted to facilitate the creation of protocols for referral to service providers and for collaboration among multisector service organizations.
- Governments and private grant makers should fund services in ways that enable and promote interagency collaboration.

Practice

- Practitioners need to consider the specific precautions of major interventions before implementing any with domestic violence (DV) survivors. By considering a survivors’
background, trauma experience, and current needs, the practitioner can provide appropriate, survivor-centred services.

- Practitioners across service sectors (i.e., DV safety services, mental health treatment, and substance abuse treatment) should use a trauma-informed, holistic approach to identity and address violence survivors’ co-occurring emotional and mental health problems, as well as their safety and practical needs.

- DV agencies should collaborate with mental health and substance abuse treatment programs in facilitating cross-trainings and case management including service referral and coordination.

**Research**

- Future research, with rigorous research designs, is needed to determine how best to provide comprehensive intervention programs for violence survivors’ mental health and safety needs.
- Future research needs to focus on developing and evaluating interventions tailored to the emotional and mental health of diverse violence survivors.
- Future research should consider social determinants (e.g., homelessness, poverty, oppression, and racism) associated with DV, including how these issues may exacerbate and prolong both DV and women’s mental health problems.

**References**


Survivors’ emotional and mental health


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