A Conversation About… Family Violence and Mental Health – Part 2

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Host (00:01):

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

Sabin Fernbacher (00:17):

Welcome to this episode of a conversation about, my name is Sabine Fernbacher. I work as an independent consultant as a trainer, and I also teach a family violence subject at Monash University in a mental health course. I'm passionate about women's mental health and trauma and the intersection of that for individuals, for teams, for organisations, and also for systems as we will hear in a moment. So is my conversation partner, who is Professor Louise Newman, and I'm delighted to be joined by you today, Louise. Louise, of course, is a psychiatrist who works with complex trauma and who is an advocate for women's mental health services. Thanks for joining me in our second podcast, Louise.

Louise Newman (00:57):

Yes thank you very much for having me back.

Sabin Fernbacher (00:59):

Thank you. Before we go into the content, I would like to begin by acknowledging the traditional owners of the lands that both Louise and I are on today. For Louise, that's the Bunurong people of the Kulin Nation in Naarm, also known as Melbourne. And I'm today on the land of the Wadawurrung people down on the peninsula. I would also like to pay my respect and our respect to elders past, present, and future. I acknowledge First Nations people's strength, their resilience and their ongoing connection with land, waters and communities. I acknowledged sovereignty was never seated, and we also want to acknowledge people with lived experience of both family violence and mental health challenges. So today is our second podcast focusing on family violence and mental health. If you haven't had a chance to listen to the first one, you might want to go back after this one and listen to the session.

(01:55):

But before I do that, I wanted to just say a little bit more about you, Louise, and also our connection. So when I was first asked to record a podcast or talk with somebody, you were the first person that came to my mind, Louise. And that's based on a number of things, including your longstanding commitment to working in trauma and mental health among all the work you do in this space, including a focus on trauma and mental health and the intersection again for individuals, for organisations, and also for governments. You've of course also published extensively and continue to practise and lead clinical work in this area and you provide advice to government on policy and practise. And one of the times that you and I collaborated was when I was working on government policy and you provided really solid and fabulous advice on that. And when we thought back to how we first connected it was through some joint work that we were involved in and where we discovered our shared values in supporting people with the lived experience of trauma and mental health challenges and really also ultimately making services more accessible and better at working with people who've experienced both those things.

(03:04):

Since then, we've done some work together and also caught up to talk about trauma and mental health on all levels that individual, systemic and policy and research. And I know for me, working as a sole person, sometimes those conversations really anchored me and continue to anchor me and I always felt encouraged to keep going with my work. And you are a kindred spirit to me in this area of work. And I think we mentioned last time too that also for those of us who work in this, it's really important to have colleagues that we connect with across those issues, isn't it?

Louise Newman (03:34):

Yes Look, I think that's absolutely essential. There's no doubt that this is hard going sometimes that the sorts of changes we might want to see across systems and the help we want to give to individuals and services can be very tough and it's demanding and sometimes slow. So having those connections with, as you say, people that you resonate with who have similar values, I think essential. This is not the sort of work to do everything alone. Sometimes we need to be alone to focus on the issues and clarify our thinking. The more we can do collectively I think and support each other through it, the better outcomes we hopefully get.

Sabin Fernbacher (04:15):

Exactly, yes. And I was just reminded of exactly that last week at a conference that focused on compassion and it also focused on how we go about making change and how we really need to build communities or connect with other people to drive change because nobody can do any of this on our own can we? So it is really important to connect. So it's lovely to connect with you about this as well. And just for people who didn't get a chance to listen to our first episode, we're kind of building on that today. But to bring you into the space we provided last time, a little bit of an overview of family violence and mental health, some of the issues there, the connections between family violence and mental health. We talked about cursive control, including gaslighting in particular within the mental health context. So we gave some examples on how mental illness or mental health is used within the perpetration of family violence against victim survivors.

(05:09):

And we also touched on trauma-informed care and practise, and we're hoping to explore a little bit more about that today. We also wanted to talk a little bit about complex trauma and sensitive inquiry

about family violence, and we hope that we get to provide you with some examples for specific population groups and how all of those issues can intersect for some people and often make it even harder to gain good support. So there is a lot of discussion still about the understanding between the relationship of mental health and wellbeing and family violence or trauma and mental health. And we touched on this last time a little bit. There are a lot of questions still cause and effect with some strands of thinking very biological while others look also at societal kind of influences and the impact of trauma of course. Did you want to elaborate a little bit on that?

Louise Newman (06:02):

Look I think these are obviously, as we said last time, really complicated relationships and in our various work settings and services and in thinking about policy and service development, we get stuck sometimes thinking about, well, the chicken and egg question, which comes first. We are very sensitive as we should be against labelling people, many women of course who find themselves in violent abusive relationships as being somehow to blame for their own abuse and saying that they must be not able to protect themselves, have whatever issues they want to be diagnosed with and that somehow is an adequate explanation. And of course it's not and that should be avoided. On the other hand, we want to acknowledge very clearly that women who find themselves in these situations, some of whom have had long-term difficulties in finding safe relationships, some of whom may even have experienced their family of origin as one that modelled violence and they're struggling with that and it's not surprising then many of those survivors will be suffering what we might want to think about as their mental health consequences of living with violence and abuse, gaslighting, whatever else has gone on for them, which is essentially undermining their sense of wellbeing, taking away their self-esteem, making women feel disempowered, eroding self-esteem.

(07:41):

And unsurprisingly, that's associated with a lot of depression and a lot of anxiety. So the consequences are maybe what mental health services do think about. We are not so good in mental health in thinking about complex causes and factors that might contribute to these sorts of situations. And to be frank, up until more recently, we haven't actually been that good at thinking about the role of trauma as a major factor for a lot of mental, so-called mental disorder or psychological and emotional distress. We're fortunately moving into a bit of an era, at least in terms of our thinking at the moment in understanding that these things are very, very important that trauma in children we now recognise as a major factor to later development of a whole range of vulnerabilities and mental health problems that really wasn't thought about particularly clearly. There's more science behind that now and that's a positive thing.

(08:47):

We also need to think about the way in which those early developmental experiences, whether it's exposure to violence or conflict in a family right through to community level violence where whole population groups are impacted by violence and trauma, whether that's war, racism and so on, the way that impacts people's development and capacity to learn and understand and be in healthier relationships. So all of these factors are very important. So I think we need to move away from thinking it's one thing or the other, moving away from victim blaming to saying it's all to do with underlying mental illness using psychiatric diagnosis in an unhelpful way, but not forgetting that we have to, on the other hand, very importantly, acknowledge the suffering. There's no compassion in our services unless we acknowledge the ravaging and devastating impacts that trauma can have on the lives of women and of their children.

(09:56):

And that's a real social and individual cost. These are people who maybe do spend time within mental health services. Some women find themselves within acute mental health units with a whole range of difficulties associated with massive trauma that they've experienced. Children find themselves in care if a parent is not feeling able to manage them and so on. These are huge social costs as well as individuals suffering. So hopefully we're moving more in that direction. But I think the issues of who makes diagnoses and which ones they use is important because the language is so confusing. It might be that specialists working in trauma know exactly what they're talking about when they talk about complex trauma. That's one term that's used or developmental trauma related problems for children, but not everyone in the community does. And many consumers of course of services can be negatively impact by inappropriate use of more old fashioned diagnoses for one of a better term that have been used in a pejorative way by clinicians largely to describe people that we find hard, complex, difficult to manage, et cetera. And they're based on stereotypes and essentially on lack of understanding of trauma, real trauma in the lives of victim survivors and the impact and scars that that can leave in some women.

Sabin Fernbacher (11:30):

You've just touched on so many issues there, and I think we'll come back to a couple of those in a moment when it comes to actually engaging, supporting somebody who's experienced, for example, family violence and is seen by a mental health clinician and listeners might work across the broad spectrum of mental health. So it might be in primary health, but also you might a GP or a counsellor in community health service or you might work at the tertiary. And for some things we know diagnosis in systems might mean a different trajectory or support, et cetera. At the same time, I've often, when I work with people who are trying to get

(12:10):

better or do this work as well as can be, but in some ways sometimes how we support somebody, what we say to them and how we listen to them might not matter about what diagnosis if indeed they have one at all. It's about compassionate engagement and knowing how to have a conversation or how to support somebody. And maybe a little later we can give some examples, but also about the role that mental health clinicians. So if we think about mental health clinicians take in supporting someone recovering from family violence or living with family violence even, and different jurisdictions have different policies. Of course, we are both based in Victoria, so we have a very clear mandate from state government that mental health services and clinicians have a responsibility and people are being trained to work in this, not to provide a specialist family violence service, but to provide good support, appropriate support, support that is in line with current policy as well. Louis, you were talking about old labels and diagnosis and then also mentioned complex trauma. Did you want to say some more maybe around complex trauma that some people might be familiar with it and some may not, and some if we stay with women or people who experience family violence may well have experienced complex trauma whilst others may not, but did you want to touch on that a little bit more?

Louise Newman (13:29):

Sure. Look, I think probably since the 1950s, the terminology that's been used to describe the way many women who presented with a whole range of issues thought to be largely related to either early trauma in the families of origin or current relational trauma. And that wasn't a term that was used back then, but what we now call relational trauma. So trauma in the context of psychosocial relationships and

often intimate relationships, but not always, of course. And initially the terminology used in the psychiatric system anyway was the whole theory of so-called borderline personality disorder, which was actually a psychoanalytic sort of notion and no one really understands unless you're interested in all this stuff, what the history is. But essentially it described people who they said were on the border of, and that's hence the word borderline, otherwise it makes no sense at all on the border of what got called psychosis or very severe mental illness or what was called at the time neurosis, meaning a lot of anxieties and often interpersonal difficulties.

(14:46):

So it was really seen as a group of people where not enough was known at the time what they might have experienced. So it developed in that way because some of these individuals, largely women, had a range of difficulties in daily life in coping with relationships and so on. They were often negatively stereotyped as women's mental health problems always have been as being hysterical under the influence of female hormones, et cetera. These are centuries old theories. So all that got linked somehow with the diagnosis and essentially was seen as just being difficult. Women have a habit of being labelled as difficult in these situations, which is of course not at all helpful. So there's been a lot of discussion about the pejorative and unhelpful use of that label. However, just to comment that I was involved in N-H-M-R-C guideline development for approaches to service development and research for people who have this diagnosis in the DSM diagnostic and system language.

(16:00):

And look, it was noted that by some consumer representatives, and I respect their opinions on this, that for some people it is helpful to have a label if it's presented to someone as a way of validating their experiences. Some consumers felt that particularly women, they'd be going to clinicians talking about a whole range of difficulties and no one really bothered to ask in an appropriate way, tell me what's happened to you, not what's your problem, what's wrong with you, what are you experiencing? But the context of how these issues can develop what's happened to you in your life, what's stressed you? Have you experienced trauma, in other words in a sensitive way? So that's really important. Now, the label or different language that's developed in more recent years has focused on the reality of trauma in the lives of women with a whole range of these sorts of experiences.

(16:59):

So some people use the term chronic or ongoing post-traumatic stress disorder, meaning that these people have experienced a range of traumas and stress in their relationships and lives. Some have had early abuse and trauma, and that has contributed in a major way to a whole range of psychological and emotional problems. The important point is labelling it trauma related led to a much better clinical practise in my view, was very appropriate that we as clinicians, seeing women in all these situations could actually say, what has happened to you? What's the context in which you have these problems? And then start rebuilding, starting from the point of view of acknowledging the reality of what they've been through, not just giving it a name. So that was very helpful in my experience for a lot of women. So chronic PTSD because it acknowledged that trauma lives on in the mind if it's not resolved, which is what people suffer from.

(18:03):

So a lot of survivors will describe that very clearly, very bravely and with a sense of resilience getting on with their lives and activities and so on, but are still plagued sometimes by intrusive memories of traumatic experiences, still anxious in relationships and so on with good reason. So that's why the

trauma is important. Complex trauma maybe is a term that is used for people who've had that, which is not the most necessarily the most common, but common enough in mental health services, people who have experienced a mixture of both early trauma, maltreatment, abuse, sometimes frank abuse in their families of origin, poor attachment. So they have early insecurities and trauma which affects developmental processes. And that in itself can set some people up for what's really a very destructive pattern of repetition, of patterns of poor relationships. And sadly, these stories are the ones that we sometimes hear poorly portrayed.

(19:17):

Of course in the media. These are the victim survivors who often attract commentary about, well, they've done this four times before. They've had a series of difficult relationships. They learned from that. These sort of very negative, punitive critical sort of commentary, which absolutely fails to understand that this is what trauma does to the way we can think and make judgements in relationships sometimes. Now, because I work as a psychiatrist, I guess I see quite a few women in those situations. So I just today was discussing these issues with a woman who experienced abuse at home with her father and grandfather and then was trafficked, so that's severe obviously at that end of the spectrum. And violence, her mother was a victim of violence, she was exposed to this for years until she ran away as an adolescent. She then took up with a male partner who was an abuser, experienced a lot of physical abuse until they had a child.

(20:19):

And her point of leaving was when he hit the child as well, which is not uncommon in those situations. But her issues relate to the confusion that she feels about what is. And she asked me, can you tell me what is a healthy relationship? Because she didn't know how to pick one. Now that's really tragic and that's going to take a lot of work. So complex trauma applies to that group. Now in mental health facilities, we certainly see people struggling to rebuild themselves. Many do, of course, but it takes a huge determination and some degree of resilience and some reasons to do that. And sometimes having a child to care for a dependent child gives people an impetus. She has a daughter and she said to me, my daughter is not going to go through what I went through. And that's a great motivation for her.

Sabin Fernbacher (21:14):

Some of the people or women that we are kind of thinking of may well not have experienced complex trauma, but some will. As you point out, sometimes when women experience abuse as a child and part of a family where there's intimate partner violence happening as well, it can then occur. Doesn't for everybody, but for some, that's what to be expected to be abused is kind of so normalised. And this is a podcast, so dear listeners, I'm doing quotation marks, so normalised that it's just a normal part of relationships. And if somebody doesn't have different experiences than sometimes that can lead to an expectation, well, you just get abused, or this is just your role in life, et cetera. And we touched on the continuum in the first podcast around how women are treated in society and how that also manifests in relationships. So an important point.

(22:07):

Now, of course, that doesn't apply to everyone either, but certainly some women and some people will experience that in their life. The other thing that you touched on as well is that some women will separate or leave when the violence is also then directed to out their child. And there's been some research studies done that show that is the impetus. They really do not want their child to experience

this as well, which can be a motivator to leave again. We touched on last time of course, that it is incredibly difficult. Women lose jobs, lose money, lose friends, lose family. It's a huge step and a difficult one. I was just thinking of also Louise, what you were saying about where people say, oh, look at her. Why is she doing this again? And she's again involved with somebody who abuses her. The question that we're trying to change there also is why do people, and this case probably often men do this and why don't they change? It's that changing, isn't it? Sure. Somebody hopefully as you were saying, wants to learn more what is a healthy relationship? And we know that there are lots of school programmes now that start in primary school and certainly in high school as well around the country that teach young people about healthy relationships because not everybody grows up with one. And I have hope for that will support people in their lives as well, no matter what their family situation is like.

Louise Newman (23:24):

Yes, that's right. Look, I think those are very important on a social level and public health initiatives really that we can support. And it needs to be really starting not only in high schools, but developmentally appropriate sort of messaging about respect and so on. And I think we're much more of that. I think what's a harder thing to shift because it's part of our mental health services and related services culture, is this idea that a particular diagnosis explains everything about a person and their history. Diagnoses are shorthand to be used by clinicians to describe cross-sectionally, what we're seeing. A person might be depressed, they might have this sort of depression and these symptoms, they don't take the place of getting to know the person, respecting the person's experience and putting it in context. You don't catch something, even if you call it borderline personality disorder, like the common cold. It's not just floating around. It is a developmental issue. It's very much related to context and what that person has experienced that's undermined their sense of who they are and their confidence. So there's a bit of a tendency still in some systems to say, oh, well, someone who presents who's been in violent relationships must therefore have this condition. And it's the old to be colloquial about it. She asked for it. It's that sort of thing. As we see in discussions about sexual assault, it's no different.

Sabin Fernbacher (25:04):

So Louise, we were saying how we wanted to touch on trauma-informed care and practise, and we kind of have, and you've sort of introduced it without us having labelled it as such, and it's such a good reminder. And I wanted just to give a couple of examples of how people could maybe ask questions as well. Not that this is a training session, but you might want to follow up if you're not confident in it. And this is a little message to listeners of course, but that shorthand around the labelling of with diagnosis. And as you say, some people appreciate having a diagnosis because it explains something to them and it gives them access to services, et cetera, whilst others don't. And of course everybody, it's their right and it helps for some and it really is hindering for others. And you touched on that shift from what's wrong with a person to actually change and say what happened to them or what happened?

(25:53):

What's brought you here today? Those kind of questions, isn't it? Around which trauma-informed care teaches us really well. And just to remind people that trauma-Informed Care and Practise is about being sensitive to knowing that a lot of people who you'll see in a mental health context the like to have experienced trauma. And often it is talked about, if we have a curious and kind inquiry with anybody, it's probably good for anybody, no matter if they've experienced trauma or not. But it's got some cornerstones of establishing some safety, showing that we're a trustworthy practitioner, providing as

much choice as we can for the person and collaborating with the person rather than taking power away or not recognising that as clinicians or as a practitioner, that people have power to really address that and support in the person empowering themselves. One thing that trauma-informed care practise and also good practise in family violence does not suggest is to ask really pointed questions really early on or really broad ones.

(27:00):

And I just wanted to give a couple of examples of something I've come across recently where somebody was suggesting to ask, have you experienced family violence? Well, if we did a little survey of everybody who might listen to this podcast, we would have lots of different definitions, I imagine. So what one person experiences as family violence, another one doesn't. So we want to ask more gentle questions or describe behaviour because that's more likely that people find themselves. So for example, to identify when somebody talks with us if family violence actually is present is we could say, has anybody in your family done something that made you, or if they've got children and your children feel unsafe or afraid. And if that person says yes, then we would ask who that is and we need to remember there might be more than one person or we can ask things around, does that person then control your everyday activities?

(27:58):

And if the person says, I don't know what you're talking about, are you free to go and see your sister, your parents, your friend, free to go to work? Those kind of things. And then we might move into other kind of areas. We might ask some questions around physical abuse, remembering that family violence often doesn't include physical abuse, but control of another kind. So that's just a really quick mention that we want to ask questions that describe the other person's behaviour that it might be easier for someone to say, well, actually, yeah, I always get checked up how much money I spend. The kids have to be in bed by such and such. And we start to understand the person's situation. Whereas if we ask a summary question, do you experience family violence? Well, what does that really mean? And we probably also want to check with the person if they are safe to leave here today. Those kind of things. So just some examples.

Louise Newman (28:51):

The Point I'd add there is that it's also really important to look at the timing of questions, the way we use language and at what point of our meeting someone and talking with them, it's actually appropriate to ask some of these questions. Initial meetings are much more about, I guess, opening a door, allowing someone to actually have some way of talking, maybe not then, but maybe later to give them a sense of what can be asked in a gentle inquiring way and a supportive way. It's probably not the time on a first meeting with someone to ask them for detail or to distress them in a way by asking them to relive the whole range of experiences that they might have been through. It's more an opening. We don't want to be at risk of raising people's anxiety and distress and then saying, oh, well no, thanks for telling us that and thanks for sharing that, and we'll give you a phone number you can call for extra support.

(29:56):

Now, the phone number might be helpful, but I think we just have to be more sensitive to the actual impact that insensitive questions can have. The other factor that I take into account are people's different backgrounds. If we're seeing people of diverse cultural linguistic backgrounds, people who might've had other traumatic experiences in their country of origin or journey to Australia and so on,

these people often have multiple layers of stress and complexity. And the sorts of questions that we might sometimes think of asking are for some cultural groups not going to be seen as appropriate, let alone at a first meeting. So sensitivity and sensitive inquiry again means knowing about the context and knowing about people's lives. So asking in a gentle way, are there things that are happening for you in your relationships, in your family at home that are making you feel, as Sabin said, unsafe in need of greater support?

(31:01):

That's leaving that open for discussion is very important, but it has to be done in a safe way. I think there's a bit of sometimes a blunt approach to asking very sensitive material that someone might never have disclosed and not be comfortable about disclosing. We have to respect that. If we have high levels of concern about someone's safety, obviously we want to have a relationship with them where we might be able to put in place a much more supportive approach. And also in the event of having major concerns, then of course we act on that and most service protocols and so on, we'll discuss that. But I think, again, these are all the factors to do with the context and the lives that people are living.

Sabin Fernbacher (31:49):

Thanks Lou. So important reminders, isn't it about sensitive inquiry, the timing of an inquiry and keeping doors and minds, and dare I say, hearts open, that somebody may well later on feel comfortable about disclosing if they wish. So we know from victim survivors, it's right through everything around trauma that if we are open and we're inviting and we are a safe person to talk to, that the person will potentially choose when they will tell us. And if we introduce things in a way, depending on organisational policies, if an organisation has made it a policy that everybody gets asked certain things at a particular time, then we want to let them know. We ask everybody this and many people who come and see us experience these things. And do you mind if I ask you some questions? But if that's not so, then we don't want to do that and we won't introduce it either.

(32:43):

We are just about out of time. Of course, as always, we have more to talk about than we have got time. You touched on a couple of particular issues. So for people from cultural and linguistic diverse backgrounds, and I'm reminded of the LGBTQA plus community that sometimes also experiences family violence and intimate partner violence and how we need to be sensitive to somebody's life, their circumstances, e.t. And that some of it looks exactly the same, and some of it is a little bit different for different population groups, let alone people who belong to a couple of population groups. So much more to talk about and we hope that we've given you some more things to think about. Hopefully you find out some good resources that you can find on the website. I'll talk through that in a moment as well. And just some ideas about how we all need to be sensitive, thoughtful, and inquire about these issues.

(33:35):

Louise, thank you so much for joining me for this second episode, a conversation about you've been listening to me, Sabin, Fernbacher, and, Louise Newman. If you either want to learn more about Louise or myself, or if you want to access some of the resources that we mentioned and some extra ones as well, go to the landing page of this episode and follow the hyperlinks. You can find information there. MHPN also values your feedback. And on the landing page, you'll find a link to a feedback survey. Please follow the link and let us know whether you found this episode helpful, provide comments and or

suggestions about how the network can better meet your needs. Thank you for your commitment to an engagement with interdisciplinary person-centered mental health care. And thank you for listening to this episode about family violence and mental health. It's goodbye from me, Louise Newman, and from me Sabin.

Host (34:31):

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