Understanding the interconnection between violence and abuse and mental health in Black and Minoritised Women's Journeys to Healing/Recovery

Project report

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A UKRI Violence, Abuse and Mental Health Network funded project

Project background

This project was funded by the UKRI Violence, Abuse and Mental Health Network as part of its workstream on the theme of understanding violence, abuse and mental health.

The project ran for a total of 18 months

Project team:

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Lay summary

The research was aimed at exploring how structural location, systemic barriers and their specific abuse contexts converge to shape Black and minoritized (B-M) women's lived experience of violence and abuse (VA) and mental health (MH) and how they make sense of this linkage, their journeys of help-seeking and responses received and their views about what supports or compromises their healing. A collaboration between University of Warwick, Imkaan and Women and Girls Network, the research included 19 interviews with victim-survivors, two focus groups with support workers, three expert interviews, conversations between lived experience experts and a short online survey with specialist BME-led VAWG organisations. An Advisory Group of experts with lived experience provided guidance and input.

Structural and situational context shaped experiences of intersecting forms of VA, further reinforced by structural violence - hostile immigration-asylum system and discriminatory service responses – with both contributing to women's mental ill-health. The corrosive impact of VA on MH was slow and insidious; women described a complete erosion of self and hopelessness, and did not understand the linkage between VA and MH. Multiple silencing factors were identified - women were brought up to not talk about personal issues to outsiders due to gendered and racialised expectations - 'race loyalty' and pressure to be strong (strong Black woman trope), protecting family from shame, and keeping the family together – and intergenerational trauma all ultimately denied women support. Immense strength was required to challenge ideas about MH in their families and communities.

Trauma of abuse was compounded by racism. Re-traumatisation occurred when agencies-professionals failed to show professional curiosity; instead racialised stereotypes shaped responses, with the strong Black woman/angry Black woman trope and reduction of VA to 'cultural' practices denying support-protection, resulting in systemic injustice. To counteract such dehumanisation women emphasised the cruciality of specialist 'by and for' B-M services. A medicalised response and diagnosis were common responses to women's trauma, the latter readily used often after an hour's session with a psychologist. Consequences of diagnosis for those from communities already pathologized were life-long and far-reaching and viewed as an injustice against B-M survivors. However, diagnosis was embraced as well as resisted, becoming a way to be taken seriously when accessing help.

As well as challenges in healing journeys, the ways in which their experiences had positive outcomes were also highlighted though reframing and identifying positives took time and women underlined the importance of doing 'slow work' to address trauma whilst celebrating the small positives.

The quicker women received a specialist 'by and for' intervention the sooner they could repair their psychological wellbeing; when women rebuilt social links they reported greater recovery. They valued specialist trauma-informed intersectional support from the outset and ongoing, longer-term, holistic-consistent interventions delivered by those who looked like them and understood their issues-lives, alongside peer support through a supportive 'community' of survivors.

Key messages

Top 3 key messages from the project

Black and minoritized women's experiences of violence and abuse and mental ill-health are shaped by their intersectional location and situational context, creating numerous silencing pressures, and determining their access to support which once accessed was experienced as inappropriate and harming unless it was from a specialist 'by and for' organisation.

The trauma of violence and abuse was compounded by racism, with re-traumatisation occurring when agencies-professionals' responses were shaped by racialised stereotypes (strong Black woman/angry Black woman and 'cultural practices' tropes) and inability to link VA and MH, denying women support-protection and resulting in systemic injustice; to counteract such dehumanisation women emphasised the cruciality of specialist 'by and for' B-M services.

A medicalised response and diagnosis were common responses to women's trauma, with the consequences of diagnosis for those from already pathologized communities being life-long and far-reaching; women valued specialist trauma-informed intersectional support from the outset and ongoing, longer-term, holistic-consistent interventions delivered by those who looked like them and understood their issues-lives, alongside peer support through a supportive 'community' of survivors.

Scientific summary

The direct relationship between domestic and sexual violence and mental ill-health, noted to be extremely complex, has been widely documented in research (Howard et al., 2010a; Humphreys and Thiara 2003; Oram et al., 2017; Rees et al., 2011; Scott and McManus, 2016). Literature has consistently shown that victims of domestic and sexual violence are at increased risk of depression, anxiety, post-traumatic stress disorder, suicidal ideation and attempts (see Chandan et al., 2019; Rees et al., 2011). Much of this existing literature has little to say about Black and minoritized (B-M) women though some research has highlighted the differentiated experiences of mainly South Asian women (see Chantler et al., 2001; Siddiqui and Patel, 2010). Recognising ongoing consequences of violence-abuse (VA) in a time of austerity, as well as additional challenges created by the pandemic, made this research timely-necessary.

The research sought to explore how structural location, systemic barriers and their specific abuse contexts converge to shape B-M women's lived experience of violence-abuse and mental ill-health and how they make sense of this linkage, their journeys of help-seeking and responses received and their views about what supports or compromises their healing. As a collaboration between University of Warwick and Imkaan (with Women and Girls Network), the research included 19 interviews with victim-survivors, two focus group discussions with support workers, three expert interviews, conversations between lived experience experts from the research Advisory Group and a short online survey with specialist BME-led VAWG organisations. The research was advised by an Advisory Group of experts with lived experience (x7), whose involvement was facilitated by Imkaan and Women and Girls Network, both organisations with a long history of work on VAWG and B-M victim-survivors. Ethical approval was gained from the University of Warwick Health and Social Sciences Research Ethics Committee.

Intersectional location and situational context created nuance and complexity for B-M survivors, shaping their experiences of interconnected forms of VA. Specific experiences highlighted included: greater level and intensity of VA across the life course; VA endured over long periods; greater levels of extreme social isolation and emotional neglect; surveillance, coercion and intimidation by multiple people; abuse of insecure immigration status; high levels of sexual violence and economic abuse/dependence; and multiple silencing factors - all aimed at securing compliance and subordination. Abuse in personal lives contributed significantly to women's mental ill-health and was reinforced by structural violence, through a hostile immigration and asylum system and discriminatory service responses, which further undermined women's wellbeing.

The corrosive impact of VA on women's MH was a slow insidious process. Women described a complete erosion of self and feelings of hopelessness, and not understanding the linkage between VA and MH. Those subjected to childhood abuse had lived with multiple manifestations of mental ill-health for decades and faced numerous challenges, most often without any form of help. Younger women attributed their lack of awareness about what they were going through to the silence, denial and stigma of MH in B-M communities.

Multiple silencing factors were identified: a sense of shame (personal and family-community) featured large in women's narratives in the face of stigma attached to both VA and MH. Women had been brought up to not talk about personal issues with outsiders due to gendered and racialised expectations - because of 'race loyalty' and pressure to be strong (strong Black woman trope), protecting family from shame, and keeping the family together - and compounded their psychological distress especially when women were not heard by those they sought out to speak to. Responses from their family-friends networks varied - some labelled them as 'crazy or stupid or dumb'. Links with past histories and intergenerational trauma created pressure to appear strong, something that denied survivors help and support and it took strength for women to challenge these ideas about MH in their families and communities. It is only with support that women started to make the connections for themselves.

A re-traumatising system: The trauma of abuse was complicated by the trauma of racism, historic and current, for women. Historical legacies of being the 'racialised other' (transgenerational and inter-generational trauma) entangled with contemporary mutations were themselves regarded as causing mental ill-health. In the face of the dehumanisation they experienced, women repeatedly asked the question – 'why can't we be seen as human beings?' Re-traumatisation by a system meant to support was considered to create greater harm than interpersonal abuse. Agencies-professionals failed to ask and listen to women's distress (no professional curiosity), instead racialised stereotypes shaped their responses, resulting in help denied – the strong Black women/angry Black woman trope and reduction of VA experiences to 'cultural' practices denied support and protection and created systemic injustice. To counteract dehumanisation by agencies-professionals women emphasised the cruciality of specialist 'by and for' B-M services.

Medicalised response and diagnosis common response: professional failure to engage with women's histories of abuse through lack of engagement with underlying cause of MH challenges (life events grounded in race and gender) resulted in a medicalisation of trauma. Diagnosis was readily used, often after an hour's session with a psychologist, something that women resisted and critiqued and attributed to racism. The consequences of diagnosis for those from communities already pathologized were immense - women viewed it as an injustice against B-M survivors, with lifelong and far reaching, and stigmatizing, implications for their lives. Women urged professionals to take a holistic view of their lives-experiences and link abuse and trauma before making decisions about the nature of interventions required. However, diagnosis was embraced as well as resisted - in the face of professionals with no understanding of the linkage between VA and MH, a diagnosis became a way for some to be taken seriously. Navigating access to help was equated with performing, to show the worst of themselves to be regarded as a deserving victim, which itself could take its toll on mental wellbeing.

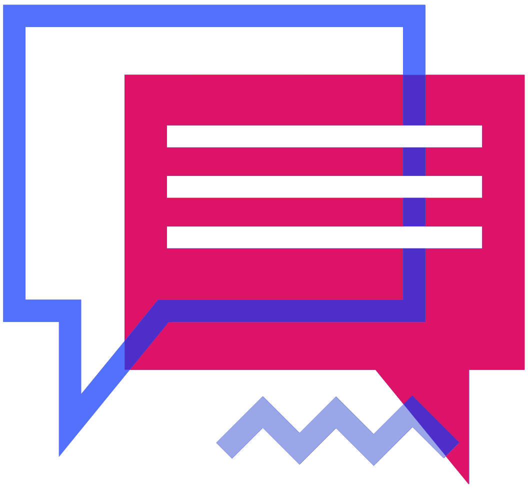
Strength and resilience - as well as the challenges encountered during their healing journeys, the ways in which their experiences had positive outcomes were also highlighted though reframing their experiences and identifying positives took time and women underlined the importance of doing ‘slow work’ to address trauma whilst celebrating the small positives. Being able to: enjoy life, see the colour in it, and to be stable in life was a source of great pride and affirmation; to withstand all that they had to contend with and share this in a way that would be helpful to other survivors, and potentially make a difference to the way in which services were shaped, highlighted to them their strength and resilience. This was especially so for those who had dealt with trauma most of their lives, received little positive interventions, been diagnosed and medicated but resisted.

What supports - the quicker women received a specialist ‘by and for’ intervention the sooner they could repair their psychological wellbeing; when women rebuilt social links and support they reported greater and speedier recovery. Readiness (after securing safety) was crucial in their healing journeys. They valued: specialist trauma-informed intersectional support from outset – ‘by and for’ specialist support-therapeutic support; ongoing, longer-term, holistic and consistent interventions; having someone who looks like them and understands to listen/hear; peer support - a supportive ‘community’ of survivors; support to make connections and un-silencing the silencing; better co-ordination between services – better signposting; more effective multi-professional training on linkage between VA and MH/trauma-informed responses to B-M survivors.

Outputs

- The enhanced understanding from the research was intended to contribute to research knowledge, to inform the policy work of Imkaan, feed into wider conversations (such as the Women's Aid campaign on mental health and domestic violence) and to strengthen practice responses.
- The full research report will be widely disseminated within research networks and the violence against women and girls sector. A shorter 'call to action' will be used strategically to communicated findings and recommendations to policy makers, commissioners and funders. Academic articles (x2) will be submitted to peer reviewed journals.
- A webinar aimed at targeted policy makers, commissioners and funders is scheduled to take place in early December 2023.
- Webinars targeted at Imkaan members and Women and Girls Network are scheduled for November 2023.
- A conference presentation will be made at the European Conference on Domestic Violence in Iceland In September 2023.

Further opportunities will be developed in 2024.



The Violence, Abuse and Mental Health Network

We will be sure to keep our members updated on any outputs linked to this project in the future. To keep updated you can sign up to our mailing list and receive our monthly newsletter. You can also follow us on our socials . All links can be found at the bottom of this page.

About the VAMHN

We are a network of individuals and organisations aiming to reduce the prevalence of mental health problems by addressing associated violence and abuse, particularly domestic and sexual violence. We bring together and support research by experts from a range of disciplines, sectors, and backgrounds - some with personal experience, others with expertise from the work that they do, and survivor researchers with both.

The activities of the network are organised into 3 themes:

Measurement	Measuring the extent and impact of domestic and sexual violence in relation to mental health. Our first year activities focused on the theme of measurement
Understanding	Understanding the pathways that lead to domestic and sexual violence and their relationship to mental health problems
Intervention	Planning interventions and services to prevent, reduce and address domestic and sexual violence in people with mental health problems or at risk of developing mental health problems

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