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VISION

University of BRISTOL
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Intimate partner violence and mental health of parents and children

Gene Feder

June 27th 2023

Claire Powell, Shabeer Syed, Emma Howarth, Ruth Gilbert, Sigrun Clark, Lauren Herlitz, Jessica Deighton, Laura Howe, Rebecca Lacey

UCL

Questions we tried to answer

- What are the interactions and resilience mechanisms? (ALSPAC)

Questions we tried to answer

- What are the interactions and resilience mechanisms? (ALSPAC & MCS)
- Is the relationship visible in the GP record? (CPRD-HES)
- What is the mental health support in services for children exposed to DA & what is the recognition/engagement with DA in child mental health services (qualitative study)

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Qualitative & **quantitative** projects exploring the interrelationships between **intimate partner violence** (IPV) and **parent and child mental health** to inform **'whole family'** service responses
Findings are relevant to policy and **practices in healthcare**, particularly primary care, and to related services that **respond to IPV and/or mental health** in adults and children.

Quantitative Component

Avon Longitudinal Study of Pregancy and Childhood (ALSPAC) birth cohort

Linked GP and Hospital data (CPRD & HES)

+

Qualitative Component

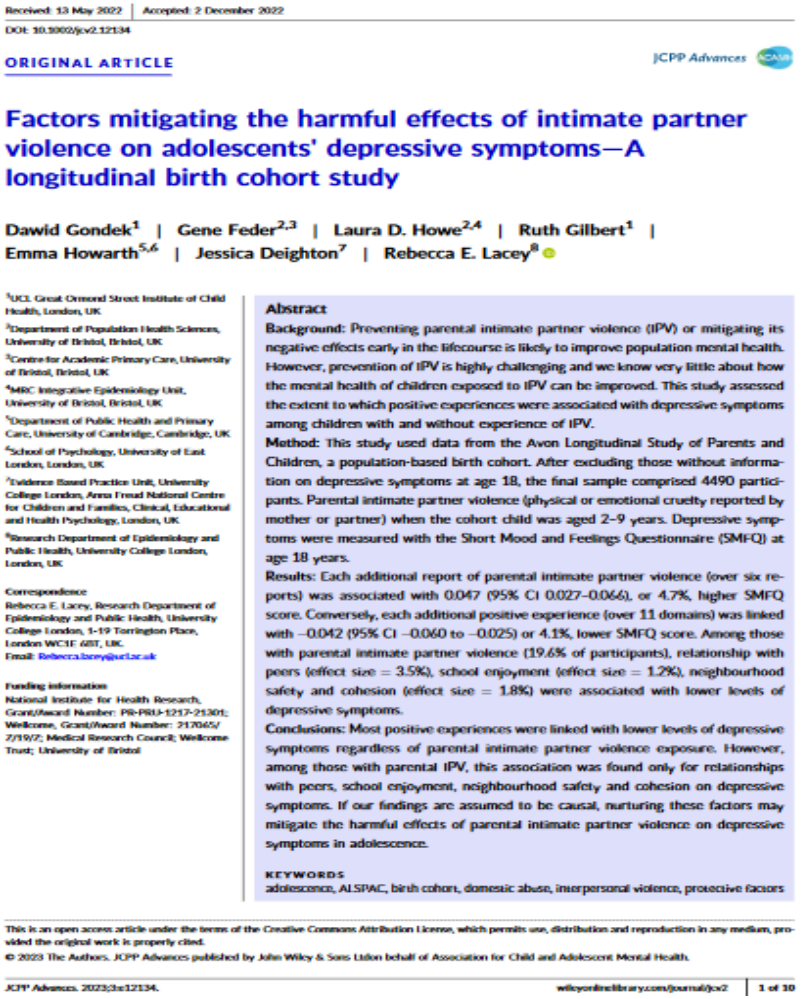
Primary care

Child mental health care

Specialist domestic abuse services

Factors mitigating association of IPVA with adult depressive symptoms

- ALSPAC analysis
- Each additional report of parental intimate partner violence (over six reports) was associated 4.7%, higher SMFQ score
- Conversely, each additional positive experience (over 11 domains) 4.1%, lower SMFQ score
- Among those with parental intimate partner violence (19.6% of participants), relationship with peers, school enjoyment neighbourhood safety and cohesion were associated with lower levels of depressive symptoms



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ORIGINAL ARTICLE

JCPP Advances

Factors mitigating the harmful effects of intimate partner violence on adolescents' depressive symptoms—A longitudinal birth cohort study

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Abstract

Background: Preventing parental intimate partner violence (IPV) or mitigating its negative effects early in the lifecourse is likely to improve population mental health. However, prevention of IPV is highly challenging and we know very little about how the mental health of children exposed to IPV can be improved. This study assessed the extent to which positive experiences were associated with depressive symptoms among children with and without experience of IPV.

Method: This study used data from the Avon Longitudinal Study of Parents and Children, a population-based birth cohort. After excluding those without information on depressive symptoms at age 18, the final sample comprised 4490 participants. Parental intimate partner violence (physical or emotional cruelty reported by mother or partner) when the cohort child was aged 2–9 years. Depressive symptoms were measured with the Short Mood and Feelings Questionnaire (SMFQ) at age 18 years.

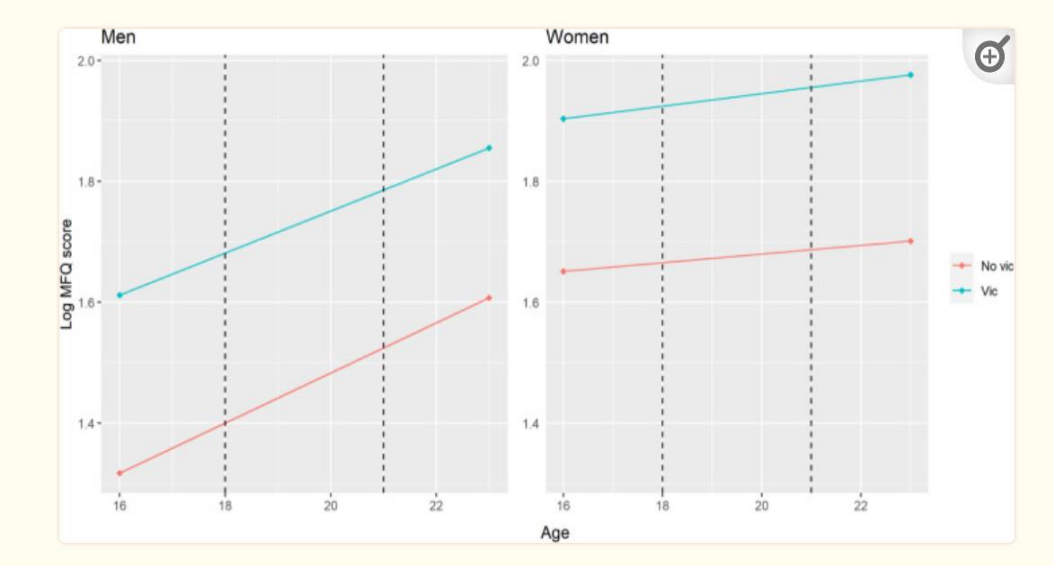
Results: Each additional report of parental intimate partner violence (over six reports) was associated with 0.047 (95% CI 0.027–0.066), or 4.7%, higher SMFQ score. Conversely, each additional positive experience (over 11 domains) was linked with −0.042 (95% CI −0.060 to −0.025) or 4.1%, lower SMFQ score. Among those with parental intimate partner violence (19.6% of participants), relationship with peers (effect size = 3.5%), school enjoyment (effect size = 1.2%), neighbourhood safety and cohesion (effect size = 1.8%) were associated with lower levels of depressive symptoms.

Conclusions: Most positive experiences were linked with lower levels of depressive symptoms regardless of parental intimate partner violence exposure. However, among those with parental IPV, this association was found only for relationships with peers, school enjoyment, neighbourhood safety and cohesion on depressive symptoms. If our findings are assumed to be causal, nurturing these factors may mitigate the harmful effects of parental intimate partner violence on depressive symptoms in adolescence.

KEYWORDS
adolescence, ALSPAC, birth cohort, domestic abuse, interpersonal violence, protective factors

Causal relationship between mental health problems and IPV in young adults?

- Most longitudinal studies show bidirectionality
- In an ALSPAC analysis evidence strongest for mental health (depression) vulnerability in 18-21 year olds:



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BMC Medicine

RESEARCH ARTICLE Open Access

Exploring the causal role of intimate partner violence and abuse on depressive symptoms in young adults: a population-based cohort study

Annie Herbert[1,2], Jon Heron[1,2], Maria Barnes[1,3], Christine Barter[4], Gene Feder[1,3], Khadija Meghrawi[5], Eszter Szilassy[1,3], Abigail Fraser[1,2,6] and Laura D. Howe[1,2*]

Abstract

Background: Previous studies have shown an association between experience of intimate partner violence and abuse (IPVA) and depression. Whether this is a causal relationship or explained by prior vulnerability that influences the risk of both IPVA and depression is not known.

Methods: We analysed data from the Avon Longitudinal Study of Parents and Children prospective cohort (N = 1764 women, 1028 men). To assess the causal association between IPVA at 18–21 years old and logged depressive symptom scores at age 23, we used (i) multivariable linear regression, (ii) inverse probability of treatment weighting (IPTW), and (iii) difference-in-difference (DiD) analysis, which compared the mean change in logged depressive symptom scores between ages 16 and 23 between those who experienced IPVA and those who did not.

Results: Women who experienced IPVA had on average 26% higher depressive symptom scores after adjustment for measured confounders (ratio of geometric means 1.26, 95% *CI* 1.13 to 1.40). In men, the difference was 5% (ratio of geometric means 1.05, 95% *CI* 0.92 to 1.21). Results from IPTW analysis were similar. In the DiD analysis, there was no evidence that being exposed to IPVA affected the change in depressive symptom scores over time compared to being in the non-exposed group for either women (difference-in-differences 1%, −12 to 16%) or men (−1%, −19 to 20%).

Conclusions: Multivariable linear regression and IPTW suggested an association between IPVA and higher depressive symptom score in women but not men, but DiD analysis indicated a null effect in both women and men. This suggests the causal origins of higher depressive symptoms in this young adult population are likely to reflect prior vulnerability that leads to both higher depressive symptoms and increased risk of IPVA exposure.

Keywords: Intimate partner violence, Young adult, Cohort studies, Depressive disorder

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Other childhood factors increasing vulnerability to IPV in young people

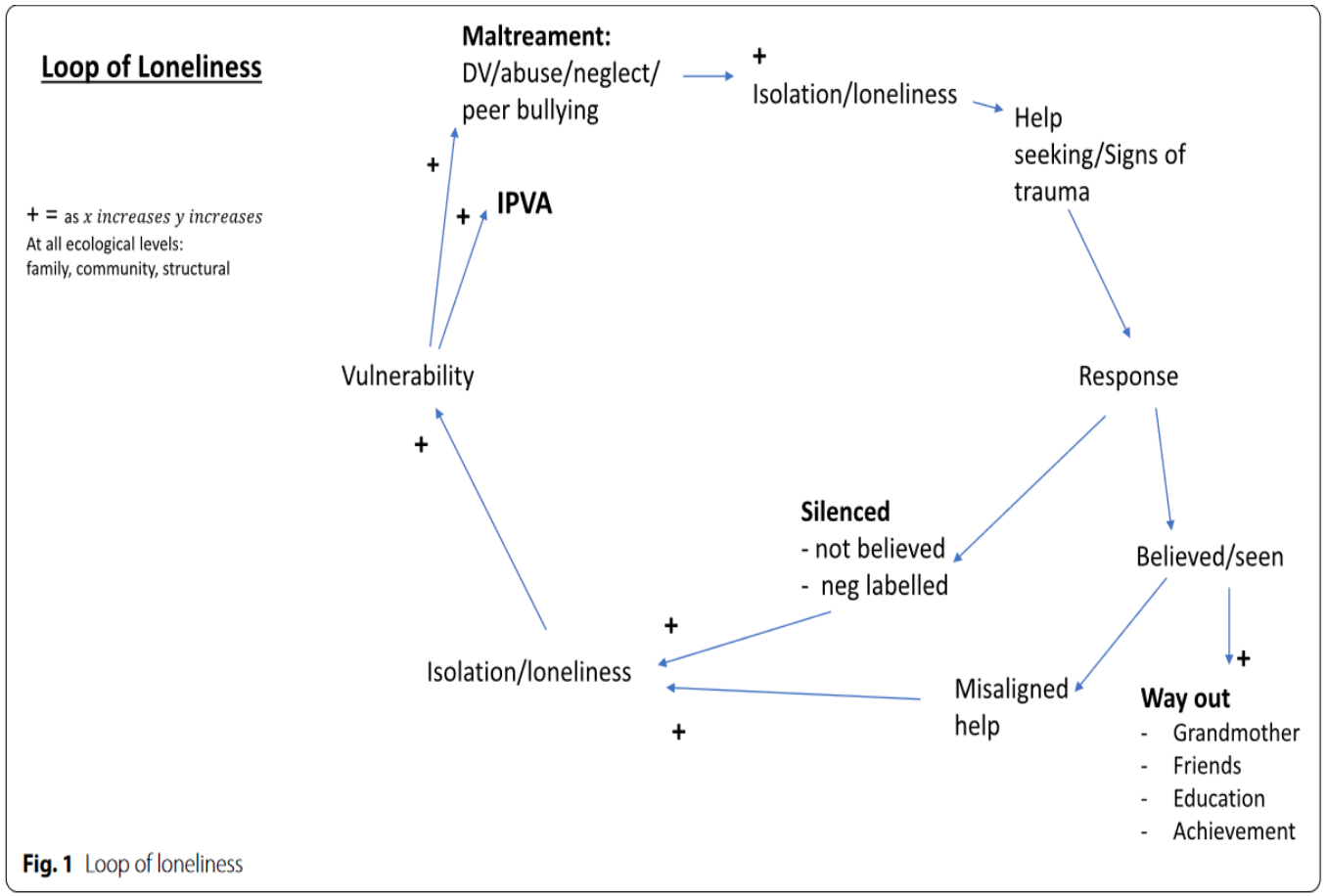

Fig. 1 Loop of loneliness

RESEARCH Open Access

Being silenced, loneliness and being heard: understanding pathways to intimate partner violence & abuse in young adults. a mixed-methods study

Maria Barnes[1*], Eszter Szilassy[1], Annie Herbert[1], Jon Heron[1], Gene Feder[1], Abigail Fraser[1], Laura D. Howe[1] and Christine Barter[2]

Abstract

Background: International research shows the significance and impact of intimate partner violence and abuse (IPVA) as a public health issue for young adults. There is a lack of qualitative research exploring pathways to IPVA.

Methods: The current mixed-methods study used qualitative interviews and analysis of longitudinal cohort data, to explore experiences of pathways to IPVA. Semi-structured Interviews alongside Life History Calendars were undertaken to explore 17 young women's (19–25 years) experiences and perceptions of pathways to IPVA in their relationships. Thematic analysis was undertaken.

Based on themes identified in the qualitative analysis, quantitative analysis was conducted in data from 2127 female and 1145 male participants of the Avon Longitudinal Study of Parents and Children (ALSPAC) birth cohort study. We fitted regression models to assess the association of child maltreatment, parental domestic violence, and peer-to-peer victimisation, by age 12, with loneliness during adolescence (ages 13–14), and the association of loneliness during adolescence with IPVA (age 18–21). Mediation analysis estimated the direct effects of maltreatment on IPVA, and indirect effects through loneliness.

Findings: All women interviewed experienced at least one type of maltreatment, parental domestic violence, or bullying during childhood. Nearly all experienced IPVA and most had been multi-victimised. Findings indicated a circular pathway: early trauma led to isolation and loneliness, negative labelling and being silenced through negative responses to help seeking, leading to increased experiences of loneliness and intensifying vulnerability to further violence and abuse in young adulthood. The pathway was compounded by intersectionality. Potential ways to break this cycle of loneliness included being heard and supported, especially by teachers.

Quantitative analysis confirmed an association between child maltreatment and loneliness in adolescence, and an association between loneliness in adolescence and experience of IPVA in young adult relationships.

Conclusion: It is likely that negative labelling and loneliness mediate pathways to IPVA, especially among more disadvantaged young women. The impact of early maltreatment on young people's wellbeing and own relationships

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Policy and practice implications: general practice and health visiting

- new presentations of ACEs with families should prompt asking about IPV
- clustering of adversity visible in child and parental records should also prompt asking about IPV
- *not* screening
- address parental mental health
- additional NICE DVA guidelines recommendation
- incorporate into IRIS training

NICE National Institute for Health and Care Excellence

NICE guideline

Domestic violence and abuse: multi-agency working

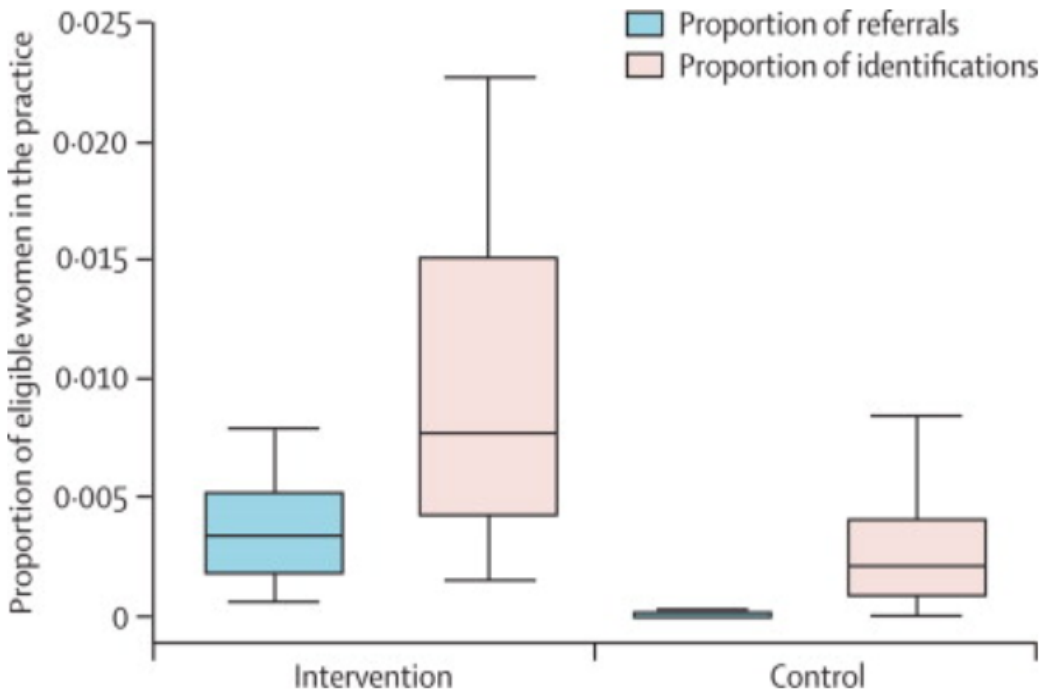
Public health guideline
Published: 26 February 2014

IRISi interventions

Policy and practice implications: CAMHS

- integration of DVA response into CAMHS commissioning – beyond safeguarding
- further training for mental health professionals
- direct referral pathway to advocacy support for parents experiencing DVA

What happens when you offer clinicians DVA training and a direct referral route to advocacy services?



Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial

Gene Feder, Roxane Agnew Davies, Kathleen Baird, Danielle Dunne, Sandra Eldridge, Chris Griffiths, Alison Gregory, Annie Howell, Medina Johnson, Jean Ramsay, Clare Rutterford, Debbie Sharp

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Summary

Background Most clinicians have no training about domestic violence, fail to identify patients experiencing abuse, and are uncertain about management after disclosure. We tested the effectiveness of a programme of training and support in primary health-care practices to increase identification of women experiencing domestic violence and their referral to specialist advocacy services.

Methods In this cluster randomised controlled trial, we selected general practices in two urban primary care trusts, Hackney (London) and Bristol, UK. Practices in which investigators from this trial were employed or those who did not use electronic records were excluded. Practices were stratified by proportion of female doctors, postgraduate training status, number of patients registered, and percentage of practice population on low incomes. Within every primary care trust area, we randomised practices with a computer-minimisation programme with a random component to intervention or control groups. The intervention programme included practice-based training sessions, a prompt within the medical record to ask about abuse, and a referral pathway to a named domestic violence advocate, who also delivered the training and further consultancy. The primary outcome was recorded referral of patients to domestic violence advocacy services. The prespecified secondary outcome was recorded identification of domestic violence in the electronic medical records of the general practice. Poisson regression analyses accounting for clustering were done for all practices receiving the intervention. Practice staff and research associates were not masked and patients were not aware they were part of a study. This study is registered at Current Controlled Trials, ISRCTN74012786.

Findings We randomised 51 (61%) of 84 eligible general practices in Hackney and Bristol. Of these, 24 received a training and support programme, 24 did not receive the programme, and three dropped out before the trial started. 1 year after the second training session, the 24 intervention practices recorded 223 referrals of patients to advocacy and the 24 control practices recorded 12 referrals (adjusted intervention rate ratio 22·1 [95% CI 11·5–42·4]). Intervention practices recorded 641 disclosures of domestic violence and control practices recorded 236 (adjusted intervention rate ratio 3·1 [95% CI 2·2–4·3]). No adverse events were recorded.

Interpretation A training and support programme targeted at primary care clinicians and administrative staff improved referral to specialist domestic violence agencies and recorded identification of women experiencing domestic violence. Our findings reduce the uncertainty about the benefit of training and support interventions in primary care settings for domestic violence and show that screening of women patients for domestic violence is not a necessary condition for improved identification and referral to advocacy services.

Funding Health Foundation.

Introduction

Domestic violence is threatening behaviour, violence, or abuse (psychological, physical, sexual, financial, or emotional) between adults who are relatives, partners, or ex-partners. It is a severe breach of human rights with profound health consequences, particularly for women who, compared with men, experience more sexual violence, more severe physical violence, and more coercive control from their partners.[1–3] The life-time population prevalence of physical and sexual violence varies internationally from 15% to 71%[4] and is consistently higher in women seeking health care,[5] including primary care.[6]

Domestic violence damages health.[7] Survivors have chronic health problems including: gynaecological disorders,[8] chronic pain,[9] neurological symptoms,[8] gastrointestinal disorders,[8] and self-reported heart disease.[10] The most prevalent effect is on mental health, including persistent post-traumatic stress disorder, depression, anxiety, suicidal ideation, and substance misuse.[11,12] Healthcare services, particularly primary care, can be a survivor's first or only point of contact with professionals[13] and abused women identify doctors as the professionals from whom they would most like to seek support.[14] The magnitude of the health consequences of domestic violence contrasts

Policy and practice implications: CAMHS

- integration of DVA response into CAMHS commissioning – beyond safeguarding
- further training for mental health professionals
- direct referral pathways for advocacy support to parents experiencing DVA
- further develop embedding models with DVA sector and LA children's services

Policy and practice implications: domestic abuse sector

- Seek commissioning of support programmes for children experiencing DVA
- Develop mental health professional consultancy model and/or embedding of mental health care professionals
- Further develop embedding of DVA advocates/IDVAs with mental health services and LA children's services

Acknowledgements

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- This study is based on data from the CPRD obtained under licence from the UK Medicines and Healthcare products Regulatory Agency. The data is provided by patients and collected by the NHS as part of their care and support. Hospital Episodes Statistics, and Office for National Statistics copyright (2023), reused with the permission of The Health and Social Care Information Centre. All rights reserved.

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CALIBER

CPRD

NHS Great Ormond Street Hospital for Children NHS Foundation Trust

UCL GREAT ORMOND STREET INSTITUTE OF CHILD HEALTH

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