Research Article

Substance Use as a Coping Mechanism for Survivors of Intimate Partner Violence: Implications for Safety and Service Accessibility

Violence Against Women
2021, Vol. 27(2) 108–123

DOI: 10.1177/1077801219882496
journals.sagepub.com/home/vaw
SAGE

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Abstract

This study examined substance use disorder (SUD) and mental health (MH) among survivors of intimate partner violence, with data collected from 102 participants. Both survivors and service providers emphasized SUD and MH as top priorities and reported a high prevalence of post-traumatic stress disorder (PTSD), depression, anxiety, and low self-esteem coupled with increasing rates of heroin, methamphetamine, and pharmaceutical abuse. Emergent themes included (a) trauma impacts functioning, (b) substances as coping strategy, (c) weighing safety against need, (d) lacking SUD and MH services, and (e) need for comprehensive and culturally specific resources. Scarcity of funding demands cross-sector collaboration to support survivors.

Keywords

intimate partner violence, substance use, trauma

Intimate partner violence (IPV) is a pressing threat to health and safety in the United States, with more than one in three women and one in four men experiencing sexual violence, physical violence, and/or stalking by an intimate partner (Black et al., 2011). Compared to national statistics, Utah reports slightly elevated rates for women, with

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nearly two in five women reporting the experience of rape, physical violence, and/or stalking by an intimate partner in their lifetimes (Black et al., 2011). Seeking emergency shelter can be anxiety-provoking, and IPV service providers tend to emphasize meeting basic needs to bolster survivors' sense of security and stability (Murray et al., 2015). However, survivors often have complex needs, including substance use disorder (SUD) and mental health (MH) issues, that extend beyond those of basic needs only. Moreover, service providers have reported that SUD and MH needs themselves represent barriers to safely engaging with survivors in IPV services (Martin, Moracco, Chang, Council, & Dulli, 2008; Murray et al., 2015).

The association between trauma and substance use has been documented in the research literature (Flanagan, Jaquier, Overstreet, Swan, & Sullivan, 2014; Jester, Steinberg, Heitzeg, & Zucker, 2015), and the prevalence of SUD and MH issues among survivors of IPV has been well-established (Bonomi et al., 2009; Coker et al., 2002; Devries et al., 2014; Helfrich, Fujiura, & Rutkowski-Kmitta, 2008; Ouellet-Morin et al., 2015; Schumacher & Holt, 2012; Smith, Homish, Leonard, & Cornelius, 2012; Sullivan & Holt, 2008). While coping expectancy was determined to mediate the relationship between early childhood trauma and later-in-life alcohol use (Jester et al., 2015), avoidance coping was found to mediate the relationship between both physical and sexual IPV victimization and substance use (Flanagan et al., 2014). Despite evidence of the significance of both SUD and MH issues among survivors seeking shelter, IPV service providers have reported deficits in training and resources to serve this highly vulnerable group (Martin et al., 2008; Murray et al., 2015). The lack of adequate training and resources has led some IPV service providers to divert survivors to SUD- and MH-specific treatment prior to permitting access to IPV-specific services (Murray et al., 2015). Thus, SUD and MH issues often go unmet in domestic violence (DV) service organizations (Lyon, Lane, & Menard, 2008).

Organizational regulations further complicate service provision for survivors of IPV experiencing SUD and MH issues. "Zero-tolerance" substance use policies, limits on survivors' length of stay, and the prioritization of housing and employment over SUD and MH treatment may neglect and/or exacerbate trauma symptomology. Indeed, some survivors have reported that shelter rules actually increase their emotional distress (Glenn & Goodman, 2015). Guided by policy and/or safety concerns, DV shelter staff have been known to turn away active substance users (Martin et al., 2008). However, these survivors may be the most in need (Poole, Greaves, Jategaonkar, Mccullough, & Chabot, 2008). "Zero-tolerance" policies can leave survivors without a safe place to address their SUD and MH needs and/or result in survivors feeling as if they have traded one controlling environment (i.e., perpetrator) for another (i.e., shelter; Glenn & Goodman, 2015). Survivors with active substance use problems have been shown to reduce the frequency of their use while participating in substance use interventions at shelter sites (Poole et al., 2008), suggesting the benefits of treatment in these settings. Furthermore, shelters offering integrated SUD services have been found to increase survivor self-efficacy and reduce substance use (Bennett & O'Brien, 2007).

Introduction to the Present Study

This research study was part of a larger statewide needs assessment to identify the specific obstacles survivors of IPV face in Utah. One research question guided this qualitative research study, "What are the obstacles to obtaining safety and stability for survivors of IPV in Utah?" Identified themes were numerous, but this article will concentrate on those specifically related to SUD and MH among survivors of IPV, namely, trauma's toll on survivor functioning, reliance on drugs and alcohol to cope, safety concerns, and SUD and MH treatment unavailability and inaccessibility. Research typically presents service provider perspectives only, rarely providing a synergistic view of IPV, SUD, and MH. Therefore, the present study is unique in its inclusion of survivor voices in addition to service providers to paint a holistic account of the lived experiences of survivors with SUD and MH concerns.

Method

This research study was approved by the Institutional Review Board (IRB) at the University of Utah. All participants were at least 18 years of age at the time of study and currently living in the state of Utah. This section will cover the study's sampling and recruitment strategy, data collection, measures and processes, participant characteristics, and data analysis.

Sampling and Recruitment

Purposive sampling was utilized to reach survivors and service providers to ensure that all regions of Utah, including both urban and rural areas, were represented. The researchers hypothesized that the prevalence of substance use and the availability of and accessibility to services would differ by geographic region. As well, targeted sampling was utilized to ensure participation of hard-to-reach populations, such as plural families, immigrants, LGBTQ+ persons, and tribal communities. This targeted sampling was intended to explore survivors' experiences through an intersectional frame, as it was hypothesized that minoritized and marginalized populations would encounter added barriers to accessing "helping systems."

For the purposes of recruitment, "service provider" was defined as a person who devotes a significant amount of time responding to IPV as a function of their employment. However, the majority of service providers worked in DV service organizations at the time of the study. The research team collaborated with the state DV coalition to identify organizations serving survivors of IPV. A victim's advocate, associated with this coalition, made initial contacts with agencies to assess their interest in participating in the research study. Then, the victim's advocate and a member of the research team worked together to schedule and arrange the locations for the focus groups. Service providers who expressed interest in participating were emailed a flyer with the date, time, and location of the focus group in their area. Service providers were encouraged to forward this flyer to other service providers who may be interested in participating. This means that focus groups were typically cross-pollinated, with several different

agencies represented in a single focus group. English-speaking ability was a requirement for study participation.

The majority of survivor participants were recruited through DV service organizations. The research team created separate flyers for survivor focus groups. These were emailed to various organizations serving survivors of IPV, and staff at these organizations posted the flyer and verbally publicized the research study. Survivor focus groups were typically held in agency settings, meaning that residents of the agency were able to attend with relative ease and were permitted to drop-in to the focus group. Snowball sampling was apparent as some survivors advertised the research study to their fellow survivors. Recruitment continued until data saturation was reached, meaning that the same ideas were being repeated by participants across focus groups/interviews.

Focus groups and interviews were conducted with 102 participants, including 43 survivors of IPV and 59 service providers. Survivors were 39.86 years of age on average, and the mean age of service providers was 43.26 years. All survivors identified as female, while 89.8% of service providers did so. Self-identified male and transgender staff accounted for 8.5% and 1.7% of the service provider sample, respectively. The majority of survivors identified as straight or heterosexual (74.4%) followed by LGBQ (9.3%) and no answer (16.3%). More than 80% of service providers identified as straight or heterosexual, 3.4% as LGBQ, and 15.3% did not complete this item. Predominantly, participants identified as White (65.1% for survivors, 88.1% for service providers) or Native American (20.9% for survivors, 8.5% for service providers). More than half of survivors and service providers identified as religious as indicated by a dichotomous "yes/no" item with a fill-in-the-blank option for participants to specify their religious affiliation.

Nearly two-thirds of service providers had a college degree followed by some college (27.1%) and high-school diploma/General Educational Development (GED; 8.5%) and did not graduate high school (1.7%).

As previously stated, great care was taken to insure the inclusion of various geographic regions in Utah. Urban counties were defined as areas with populations equal to or greater than 65,000 (see Voices for Utah Children, 2016). Counties with populations between 20,000 and 64,999 were considered urban/rural areas, and those with populations under 20,000 were labeled as rural areas. Survivor participants indicated in which county/counties they accessed IPV-related services with the final breakdown being in urban areas (44.2%), urban/rural areas (25.6%), and rural areas (20.9%). The remaining survivors reported that they had not attempted to access services related to IPV. Please see Table 1 for additional demographic information.

Data Collection

In-depth, semi-structured focus groups and interviews were conducted with survivors of IPV and service providers throughout the state of Utah from March 2016-February 2017. Focus groups were conducted separately for survivors to ensure that they felt comfortable sharing their concerns without fear of reprisal. Eight focus groups were conducted with survivors of IPV, and nine focus groups were held with service

Table 1. Demographics of Study Participants.

	Survivors ($n = 43$) *M* (*SD*)	Service providers ($n = 59$) *M* (*SD*)
Age	39.86 (12.75)	43.26 (12.65)
	Count (%)	Count (%)
Gender identity		
Female	43 (100)	53 (89.8)
Male	0 (0)	5 (8.5)
Transgender	0 (0)	1 (1.7)
Sexual orientation		
LGBQ[a]	4 (9.3)	2 (3.4)
Straight/heterosexual	32 (74.4)	48 (81.4)
No answer	7 (16.3)	9 (15.3)
Race		
African American/Black	3 (7)	0 (0)
Asian	1 (2.3)	1 (1.7)
Native American	9 (20.9)	5 (8.5)
White	28 (65.1)	52 (88.1)
No answer	2 (4.6)	1 (1.7)
Latinx/Hispanic	4 (9.3)	6 (10.2)
Born outside United States	4 (9.3)	4 (6.8)
Education Level		
Did not graduate HS	7 (16.3)	1 (1.7)
HS diploma/GED	16 (37.2)	5 (8.5)
Some college	9 (20.9)	16 (27.1)
College degree	10 (23.3)	37 (62.7)
No answer	1 (2.3)	0 (0)
Religious	29 (67.4)	38 (64.4)

[a]LGBQ refers to lesbian, gay, bisexual, and queer.

providers. All focus groups were attended by two female members of the research team with the researcher conducting the focus group and a victim's advocate observing nonverbal behavior. The victim's advocate was also available to provide support to participants, if needed. However, some participants preferred to be interviewed individually with four survivors and two service providers selecting this option. The majority of focus groups and interviews were conducted in agency settings; however, some interviews were conducted in the first author's office or at a local cafe with the location chosen by the participant.

Measures and Processes

Informed consent and confidentiality were discussed immediately prior to each focus group and interview. Participants were informed that participation was completely

voluntary and that they were permitted to end participation at any point without penalty. Following the discussion of informed consent, each participant completed a demographic form that included items pertaining to race, ethnicity, gender, and sexual orientation. Open-ended, semi-structured interview guides were used for all focus groups and interviews. While interview guides were used, participants guided the focus groups and interviews allowing space for participants to speak to issues of most importance to them. To allow for flexibility, service providers were asked open-ended questions such as "In your opinion, what are the largest barriers to victims of domestic violence accessing services at your agency?" and "Are there any issues facing victims that the public/law enforcement/clergy/etc. are not aware of, and should be?" Similarly, survivors were asked questions such as "What are some of the biggest obstacles you have faced when looking for help?" and "How did you learn about services available, and how long did it take you to try to access them?" All focus groups and interviews were conducted in English and lasted between 1 and 2 hr. Survivors received a US$20 grocery gift card for their participation, while service providers received no incentive for participation in this research study.

Data Analysis

All focus groups and interviews were audio-recorded with the participants' consent and transcribed verbatim. Data collection and data analysis occurred simultaneously, which is common to qualitative studies. This means that transcription and data analysis occurred soon after each focus group/interview to assess emerging themes. Each transcript was read multiple times by the first two authors. Data were organized in NVivo 10 and consisted of line-by-line analysis, identifying themes, coding categories, and developing matrices to uncover relationships between themes and categories. Thematic codes were analyzed separately for survivors and service providers with the expectation that themes would differ for each group; however, themes were largely consistent across subgroups. The first two authors coded all transcripts separately and compared themes and categories to ensure inter-rater reliability. Any discrepancies were discussed between these authors and resolved prior to the selection of final categories. Confidentiality was of utmost concern; therefore, no names have been included here.

Results

Both survivors and service providers emphasized SUD and MH as top priorities and reported a high prevalence of post-traumatic stress disorder (PTSD), depression, anxiety, and low self-esteem coupled with increasing rates of heroin, methamphetamine, and pharmaceutical abuse among survivors. A service provider stated, "At least 70% [of survivors] have had either a history of substance abuse or are in active recovery at the moment." This observation of increased substance use among this population is consistent with the high rates found among the general population in Utah. In 2015, the drug overdose death rate was 23.4 per 100,000 population in

Table 2. Survivor Themes ($n = 43$).

Themes	Theme meaning	Codes
Trauma Impacts Functioning	Survivors' basic functioning was inhibited by the trauma they experienced.	*Normalcy* *Physiological issues* *Nightmares* *Panic attack* *Behavioral health*
Substance Use as a Coping Strategy	Survivors use legal and illicit substances to cope with the trauma associated with their IPV victimization.	*Substance use* *Drugs* *Addiction* *Coping* *Survival mode*
Lack of Available & Accessible Resources	Survivors struggle to get the assistance they need.	*Limited options* *Accessing help* *Obstacles*

Note. IPV = Intimate partner violence.

Utah, one of the highest rates in the nation (Kaiser Family Foundation, 2018). Survivors highlighted their trauma symptomology, which was present both during and post-abusive relationship, and how this trauma impacted their ability to complete even basic daily tasks let alone complex tasks such as securing housing and employment. The symptoms of trauma led survivors to use drugs and/or alcohol as a coping mechanism, as substance use was viewed as an immediate and accessible source of relief. Despite the complexity of survivor experiences (i.e., IPV's intersection with SUD and MH issues), establishing safety and stability is prioritized first in shelter settings. Please see Tables 2 and 3 for a description of themes by subgroup (i.e., survivors and service providers).

Trauma Impacts Functioning

Survivors spoke of the negative impact their traumatic experiences had on their health and well-being, describing how trauma affected their basic physical functions, such as sleeping and eating habits, and cognitive functions, including their ability to concentrate. A survivor illustrated the impacts of trauma saying "we [survivors] don't sleep . . . because of the trauma which is part of PTSD. . . . We even go to depression, because it's a lot of trauma and you have all that builded [sic]." This trauma also was described as manifesting physically with one survivor chronicling her experience with panic attacks when she described "waking up [in the middle of the night] . . . and just feeling like my heart was beating out of my chest, and I was completely wet in sweat and just like panicking."

Multiple survivors relayed their inability to handle considerable life changes due to their trauma experiences, illuminated by one survivor who stated, "Imagine somebody being depressed and already going through a lot of trauma so anything that just slightly

Table 3. Service Provider Themes ($n = 59$).

Themes	Theme meaning	Codes
Substance Use as a Coping Strategy	Survivors use legal and illicit substances to cope with the trauma associated with their IPV victimization.	*Coping* *Health concerns* *Rehab* *Challenges*
Weighing Safety Against Need	Staff face difficult decisions in weighing the safety of survivors and children in shelter against the needs of substance-using survivors.	*Safety* *Safety planning* *Restrictions*
Lack of Organizational Capacity and Resources	Staff struggle to meet survivors' complex needs, in part, due to lacking resources.	*Funding* *Lack of support* *Accessing help* *Accessing resources* *Economic challenges*

Note. IPV = Intimate partner violence.

makes them upset is like the world ending to us." Another survivor concurred, "Any big change for me will, like, trigger depression and trigger anxiety." Service providers echoed these corollaries of trauma, particularly related to psychological abuse, citing the effects of emotional and mental abuse as a constant struggle for their clients, leading one service provider to term survivors' distress as "visceral trauma." To illustrate the impacts of trauma, a survivor stated,

> We [survivors] can't do our normal things within our normal routine because . . . we're so consumed with that trauma . . . the first couple of weeks [after leaving an abusive relationship] you can't do anything. Like, your body's literally feeling it [trauma]. There were days I was so physically numb . . . I felt like I was hit by a Mack truck.

For marginalized and minoritized survivors, IPV-related trauma is intertwined with historical trauma. A service provider noted the impact forced assimilation (i.e., boarding schools) had on future generations of absentee parents, substance use, and DV in tribal communities. A Native American survivor connected family violence witnessing to substance use and gang involvement for youth in tribal communities saying, "so many ones still in domestic violence in my family—my cousins, their kids doing drugs already at 11 years old, 12 years old in gangs."

Service provider participants expressed sympathy for the difficulties survivors face when processing their trauma, noting that the demands of shelter are high for survivors in crisis. In Utah, service provider participants indicated that emergency shelters often set a maximum stay of 30 days; however, this is a very small window for survivors to recover from trauma, SUD and MH conditions, let alone secure housing, employment, and child care. One service provider explained, "It's kind of like you're expecting this woman to hit the ground running, and she's kind of still in trauma."

Substance Use as a Coping Strategy

To manage the symptoms of trauma, both survivor and service provider participants indicated that many survivors use drugs and/or alcohol to self-medicate as a coping mechanism. Substances were described as a means to numb emotional pain; a technique first used in relationships as a means to cope with the abuse. For example, a survivor illustrated how she used substances as an avoidance coping strategy: "My main thing was I stayed high, so I didn't have to feel. . . . So, I didn't have to deal with what was going on [IPV]." Similarly, a service provider explained that they have seen "an increase in drug use . . . it's a lot of the ways they [survivors] cope with what's been going on. They can just get high and zone out and then maybe it doesn't matter if they're beat." Survivors with family responsibilities stated that substances helped them manage their pain so that they could support their families: "I can live through the black eyes and stuff, but I mainly stayed high so I could raise my family." Furthermore, a service provider noted high rates of substance using by LGBTQ+ survivors, who, in addition to IPV-related trauma, experience systematic oppression and marginalization: "LGBTQ folks are going to have higher rates of substance use and depression. . . . It is related to the discrimination, the oppression, the rejection, the experience with their family, community, and society, and laws." Post-relationship, substance use was described as a means to cope with IPV-related trauma and the stress associated with rebuilding a life. With a set amount of time to meet milestones, such as securing housing and employment, and a lack of SUD and MH treatment, many survivors self-medicate with illegal substances.

Weighing Safety Against Need

Active substance use becomes a double-edged sword for survivors. They rely on substances to cope with trauma, but, at the same time, survivors may be evicted from shelter for safety reasons. Service providers indicated that a "revolving door" exists for survivors with SUD, and they conveyed concern about the safety and well-being of survivors and children. Due to the high prevalence of untreated SUD in their client populations, service providers reported conflicted feelings regarding if/how to balance the immediate demands of substance users with the safety needs of others. One service provider indicated that they have seen a huge increase in drug use and MH issues, and

> They [survivors] come into the shelter, and they want to check in but they're in an active mental health crisis. And we have a mom and some kids. . . . We have to weigh their [mom and kids'] safety on whether or not this person can stay at the shelter.

Another service provider went further expressing fear that children would stumble upon drug paraphernalia, such as needles. Other service providers noted the impact active users can have on the relapse of survivors in recovery. One service provider illustrated how a survivor "who's trying to stay clean and doing really well" could be

influenced by a new arrival, saying "If you have one drug user and a few that have a problem with that, it seems like they group together and all a sudden there's . . . a big drug problem in the shelter."

To a lesser extent, service providers emphasized safety-related concerns for substance users themselves, such as the potential for physical injury. One service provider illustrated this concern by saying "we've had someone who's like falling down stairs." Service provider participants indicated that their organizations lack the health-related infrastructure to address detoxing clients and active substance users. For example, a service provider emphasized that shelters are not medical facilities, and "If we have someone that's actively detoxing at the shelter, it's not safe for them to live there."

Due to a lack of appropriate on-site services and fear of losing funding, shelter staff reported rejecting entry to or terminating the stay of substance users. DV service organizations tended to institute a "zero-tolerance" policy, meaning that active substance users were not permitted to obtain and/or retain shelter at the organization. Service providers expressed that this policy discourages survivors from disclosing SUD for fear of being evicted from the shelter. Without knowledge of the full scope of the client's struggles, service providers recognized that they may be treating only a fraction of the client's needs. Thus, service provider participants reported a double-bind between ensuring safety and meeting the needs of all clients regardless of substance using.

It is important to note, though, that this theme was continuously discussed across service provider focus groups but not emphasized in those for survivors. This may suggest that (a) survivors are not particularly concerned about substance using in the shelter setting, or (b) "zero-tolerance" policies are effective in ensuring survivor safety. However, more research is needed to understand this absence.

Capacity, Availability, and Accessibility

Despite seeing an overwhelming number of clients presenting with SUD and MH conditions, service providers relayed that DV shelters are both unprepared and underfunded to treat these issues. A service provider stated, "It's almost like we're prepping them [survivors] to fail because we [service providers] can't give them the other things [SUD and MH services] that they need to be able to move on." Service providers reported being routinely tasked with triaging clients in crisis yet expressed concerns regarding their ability to provide for survivors' complex needs. Service providers relayed difficulty in assisting clients with their IPV-related issues when their SUD and/or MH issues remain unaddressed.

Service providers indicated a lack of capacity to treat addiction and mental illness in their respective agencies. As one staff member relayed, "You're kind of stuck with this gap where, we're not mental health providers and we're expected to, kind of, triage those and handle them all the same." Moreover, both survivor and service provider participants discussed a lack of access to and availability of intervention options in the broader community. This was pronounced for survivors without Medicaid or private insurance, as they lack the financial means to pay for SUD and MH services

out-of-pocket. At the time of data collection, the state of Utah had not expanded Medicaid making it impossible for survivors without children to qualify for this insurance benefit. A service provider noted,

> Another thing that we run into a lot is resources for rehabilitation, for drugs, for alcohol, even getting into mental health facilities because these people [survivors] come in, and they have nothing. They have no insurance, no money. If they don't have kids, it's hard to get them on Medicaid or CHIP [Children's Health Insurance Program].

Local addiction and MH centers may not even accept Medicaid, as noted by service provider participants regardless of geographic location. Service provider participants also discussed difficulty accessing psychiatrists and obtaining appointments for their clients. Limited availability of and accessibility to behavioral health services was especially pronounced in rural areas where there may not even be a MH facility located in the entire county. Rural survivor participants ranked lack of transportation as a major barrier to accessing services, both behavioral health and IPV-related services. Finally, service provider participants discussed the "small town stigma" associated with seeking MH services in rural communities, because "[survivors] are scared of seeking out mental health services because of the stigma associated with it and everybody knows everybody's business here."

Finally, undocumented survivors face excessive barriers to accessing resources, as they cannot even apply for benefits such as Medicaid or the Children's Health Insurance Program (CHIP). One undocumented survivor described how a lack of resources and a lengthy immigration process that "might take eight months. It may take a year. Where do I go to?" contributed to a sense of hopelessness. She went on to describe how this hopelessness could "push us to commit suicide . . . push us to go do drugs . . . or push us back to the abuser."

Comprehensive and Culturally Specific Resources

Addressing basic needs alone, especially for survivors with SUD and MH issues, is insufficient to ensuring the stability of survivors. Service provider participants communicated the importance of comprehensive services, such as

> Enough housing . . . we could get people into a safe housing situation and then deal with substance abuse . . . deal with the trauma. But without a safe place to be, [survivors are] always going to be in survival mode.

Here, "comprehensive services" refers to housing (with transitional housing favored by service providers), MH treatment, substance use treatment, and primary health care. However, service provider participants held that the funneling of governmental funding to SUD- and MH-specific agencies leaves DV service organizations without the ability to address clients' complex needs. When prompted further, service provider participants indicated a desire for funding to complete evaluation

and rehabilitation on site. In contrast, survivor participants expressed a desire to take respite from their trauma and the "victim label." One participant stated that she wanted to feel like

> A human being that's so much more than just my trauma. . . . I want to laugh. I want to have fun. . . . I want to get to not just barely surviving. I want to get to my warrior phase.

As well, Native American survivors and service providers endorsed a return to spiritual practices and tribal values to build healthy relationships and communities. For example, a Native American survivor who reported that she had been diagnosed with PTSD, severe depression, and bipolar disorder recounted how her therapist encouraged her to "pray to your ancestors" and how this return to her tribal traditions contributed to her psychological and emotional healing. Another Native American survivor with self-reported PTSD and depression diagnoses described how revisiting the struggles of her ancestors helped to contextualize her own. She said, "There's just so much that makes you appreciate life more, that makes you think my hardships are far from their [ancestors'] hardships, but they lived, and they went through it." Native American service providers also emphasized the importance of traditional values and practices but noted a lack of access to tribal ceremony and spiritual leaders or "medicine men," especially in urban areas.

Discussion

Previous literature shows a bidirectional relationship between IPV, SUD, and MH issues (Bonomi et al., 2009; Coker et al., 2002; Devries et al., 2014; Helfrich et al., 2008; Ouellet-Morin et al., 2015; Poole et al., 2008; Salom, Williams, Najman, & Alati, 2015; Schumacher & Holt, 2012; Smith et al., 2012; Stuart et al., 2008; Sullivan & Holt, 2008). The present study supports past research, with both survivors and service providers underscoring the impact of IPV on trauma and SUD. However, service providers reported being unable to meet the needs of survivors struggling with these issues, echoing previous research (Lyon et al., 2008). Furthermore, service providers reported experiencing a double bind, weighing the needs of survivors with SUD against the safety of other survivors in shelter as well as DV shelter staff, findings reflected by Martin et al. (2008) and Murray et al. (2015). Survivors and service provider participants alike relayed the toll unaddressed trauma has on survivors, including decreased physical functioning in terms of sleeping and eating habits, as well as a decrease in cognitive functioning, findings that affirm the impact of trauma on physical and MH (Afifi et al., 2009; Bonomi et al., 2009; Coker et al., 2002). Overall, service providers described being unequipped to meet the needs of survivors with SUD and MH issues due to a lack of funding, strict shelter regulations, and a lack of proper training. The present study contributes to the existing literature by highlighting trauma and SUD through the inclusive commentary of both service providers and survivors of IPV representing both rural and urban geographic regions and multiple cultural contexts.

Overall, both individual and environmental factors affect substance-using survivors of IPV. The relationship between IPV, SUD, and MH issues is, unfortunately, largely traumatic and cyclical within the context of lacking treatment options and "zero-tolerance" policies. Survivors enter DV shelters in acute traumatic states, at times using illicit substances to cope with their pain. Service providers are forced to evict substance-using survivors citing safety concerns, leaving survivors with few options.

Limitations

While this needs assessment resulted in a wealth of information, no research study is without limitations. First, all survivors of IPV who participated in this project identified as women, as the recruitment of male and gender-nonconforming participants proved to be incredibly difficult. Trauma and SUD in relation to IPV may function differently for male and gender-nonconforming survivors. Furthermore, we did not gather SUD and MH diagnosis information on the demographic form, meaning that we did not capture the prevalence of these issues among the study sample. However, the topics of SUD and MH were raised by participants in every focus group, and many survivors disclosed their diagnoses without prompting. Although, substance use was not discussed by privately interviewed survivors who never accessed shelter services, indicating that future research is needed. As well, the majority of survivor participants were currently associated with a DV service organization, namely shelter services. Survivors who never access shelter services, especially those with private insurance, may have different experiences accessing SUD- and MH-specific services. Moreover, as English language ability was an inclusion criterion for participation, this study did not capture the voices of non-English-speaking survivors who likely face amplified barriers. Finally, the majority of data collection occurred in agency settings, which may have affected participant response.

Implications

The present study adds to the growing literature base suggesting that SUD and MH issues are prominent in the IPV-survivor population. Trauma-informed care trainings should be offered to those serving survivors struggling with SUD and MH issues. IPV service providers, whether in the field of social work, MH, public health, or other service areas that intervene with survivors, should understand the impact of trauma on health and well-being, especially pertaining to SUD and MH, so as to best engage with survivors to meet their short- and long-term needs. The intersection of trauma, SUD, and MH seen in survivors of IPV is not unique to Utah. Ideally, shelter stay time limits and "zero-tolerance" policies would be amended to reflect individual survivor needs in relation to trauma and substance using.

Findings support funding and training initiatives tailored to the needs of survivors. Specific funding should be allocated to DV service organizations aspiring to provide services, such as evaluation and rehabilitation, for survivors with SUD and

MH issues. Alternatively, DV service organizations should consider partnering with local behavioral health centers for cross-referral purposes at a minimum. Unfortunately, though, many behavioral health centers are over-extended as well, and uninsured survivors endure long waitlists. For example, Utah's uninsured population can expect a 3- to 6-month wait time for addiction treatment (Lockhart, 2017). Importantly, at the time of revising this article, Utah state voters approved a ballot measure to expand Medicaid, which may increase survivors' treatment accessibility. Still, future research is needed to understand the impact of Medicaid expansion on survivors' service utilization. Again, the scarcity of resources to support IPV survivors nationally demands the integration of health care, social services, and clinical treatment programs to collaboratively support clients in shelter settings, as a means to maximize resources and holistically address survivors' needs.

Acknowledgments

The authors wish to thank the Utah Domestic Violence Coalition for their assistance with this project.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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