Section 2

Getting the whole picture

Section 2

Getting the whole picture

Section outline

This section provides an overview of the links between experiences of domestic and sexual violence, mental ill-health and substance use. Our starting point is an understanding of domestic and sexual violence as being traumatic events that survivors respond to and cope with in many different ways.

1. What is trauma?

Experiencing a traumatic event, either in childhood or as an adult, is a common starting point for mental ill-health and substance use.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (2004) defines trauma as a situation whereby someone has:

"experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others."

Bessel van der Kolk, a professor of psychiatry at Boston University School of Medicine and an expert in post-traumatic stress, defines trauma as ***"an inescapably stressful event that overwhelms people's coping mechanisms".***[1]

When understood in this way, it becomes clear that traumatic events are commonplace in our world:

- Domestic violence – according to the British Crime Survey, 1.2 million women and 800,000 men experienced domestic violence in 2010/11.

- Rape and sexual assault – 19 per cent of women and two per cent of men in England and Wales have been sexually assaulted or raped, or someone has attempted to sexually assault or rape them.[2]

- Reports of child abuse and neglect – approximately one quarter of all young adults have been severely maltreated, sexually abused and/ or witnessed domestic violence as a child.[3]

- Violent crime – there were an estimated 2.2 million incidents of violent crime in England and Wales in 2010/11.[4]

- Car accidents – in 2011 the police in England, Scotland and Wales recorded 203,950 car accidents that involved someone being injured. This includes 23,122 people sustaining serious injuries and 1,901 being killed.[5]

- Death of a parent - around 53 children and young people under the age of 16 are bereaved of a mother or father every day in the UK. [6]

- Combat – according to the Ministry of Defence,[7] over 9,000 military personnel are currently on active duty in Afghanistan alone. Many will experience trauma.

In addition to describing what typifies a traumatic event, some definitions also refer to the feelings of **"intense fear, helpless[ness], or horror"**[8] and **"life-threatening powerlessness"**[9] which can accompany the experience of trauma.

The idea of trauma as an event that makes someone feel helpless and powerless is key to understanding how survivors of domestic and sexual violence may think and behave.

Spread the word

As well as developing a solid understanding of trauma and the links with mental ill-health and problematic substance use, it is really important that we enable survivors to understand what is happening to them.

Psycho-educational work is commonplace in many settings now, and is the cornerstone of trauma work. Survivors often do not see the link between their own experiences of trauma and the difficulties they have with their mental health or substance use. Responses to trauma such as flashbacks and dissociation can also give rise to fear as well as self-blame if survivors do not understand why their minds and bodies work in certain ways.

Women's Aid, Rape Crisis, Mind and the Mental Health Foundation all provide information about common responses to experiences of domestic violence, sexual violence and trauma which survivors may find useful.

AVA's toolkit, Sane Responses, also offers succinct information about the links between domestic violence and each of the most common mental health problems and practical guidance for domestic violence and mental health workers on how to address these issues. Information about all these resources can be found in appendix H.

2. Trauma responses

There is no standard pattern in how people react to the extreme stress of traumatic experiences such as domestic and sexual violence. Some people will respond immediately, whilst others may have a delayed reaction. The length of time needed to recover also varies – some people may recover quickly and others will experience the negative effects of trauma over months or years.

There are, however, a wide range of commonly recognised emotional, physical, cognitive, behavioural and interpersonal responses to domestic and sexual violence.

2.1 Emotional

Experiencing domestic and sexual violence can give rise to many different feelings:

- Anger, rage, aggression
- Guilt, shame
- Difficulties in regulating emotions
- Fear, preoccupation with danger
- Numb, detached from feelings
- Sadness
- Depression, hopelessness
- Anxiety
- Powerlessness
- Fear of dependency

2.2 Physical

The physical impact of trauma includes injuries and other acute health problems directly related to the trauma as well as the long term impact of traumatic stress on the body.

Acute health problems: from repeated physical assaults, sexual assaults and rape; sexually transmitted diseases and pregnancy; injuries from self-harming behaviour or attempted suicide; other accidental injuries due to high tolerance of pain resulting from disconnection to body.

Stress-related problems: sleep disturbance, gastrointestinal problems (IBS), migraines, chronic fatigue syndrome, impaired immune system, chronic pelvic pain, somatisation disorder (multiple, on-going physical complaints of no distinguishable cause), eating difficulties, asthma.

All physical problems may be exacerbated by a lack of access to medical care.

2.3 Cognitive

Experiencing trauma can lead to changes in survivors' mental processing, i.e. the way they receive, transmit and operate on information. These types of changes are called cognitive responses and include:

- Difficulties concentrating and maintaining attention
- Problems with planning, making decisions, taking action

- Differing levels of dissociation, from 'spaciness' to complete detachments and disconnection
- Identity disturbance – derealisation (the world seems unreal), depersonalisation (I am unreal; living in a dream-like state), fragmented sense of self (no clear sense of identity)
- Intrusive memories – flashbacks and nightmares
- Fragmented memory, problems with recall of events and information, amnesia of parts of the trauma
- Panic attacks and exaggerated startle responses
- Phobias, obsessive compulsive behaviour
- Self-blame, self-doubt, low self-esteem and lack of confidence
- Rumination, worry cycle
- Loss of meaning and apathy
- Minimisation and denial

2.4 Behavioural

How we think and feel can influence our behaviour. Survivors often behave in ways that might seem unhealthy or even dangerous, but are often ways of coping with how they are feeling inside, or externalising their feelings and thoughts:

- Self-harming
- Suicidal ideation and attempts
- Alcohol and drug use
- Eating disturbances
- Irritability, impatience, impulsive and aggressive behaviour, anti-social behaviour
- Hypersensitive to the environment
- Risky sexual behaviour, sexual acting out, compromised sexuality
- Fiercely independent, reject help, hostile and resistant to interventions
- Loss of interest in activities

2.5 Interpersonal

Trauma is known to affect how survivors relate to others; this is particularly true when the trauma has been caused by another person rather a natural disaster. The survivor may respond to trauma with:

- Withdrawal from others, from their community
- Isolation, sense of alienation
- Difficulties with trust
- Problems relating to others, impaired mentalisation
- Difficulties with power and control
- Lack of interpersonal boundaries, lack of assertiveness in relationships
- Issues with intimacy, sexual problems
- Intolerance
- Angry outbursts
- Expectation of rejection

Incongruence and betrayal

Traumatic experiences have been referred to as being abnormal life events, i.e. outside our normal expectations of life and in contrast with what we believed in, knew or had experienced beforehand. For many survivors this contrast, or incongruence, can be the most difficult part and take the longest to come to terms with. Even survivors of long-term abuse can still be shocked by incidents of violence. Similarly, being violated by someone you should be able to trust – a parent, a relative or a partner – can evoke a strong sense of betrayal which can lead to severe trauma responses.

3. Trauma and mental ill-health

Responses to trauma often manifest themselves, and are diagnosed, as mental health problems. There is a growing evidence base to suggest a clear association, and further a potential causal relationship, between experiences of trauma, particularly being the victim of violence, and poorer mental health:[10]

- 56% of women experiencing domestic violence are diagnosed with a psychiatric disorder.[11]

- Rates of depression for survivors of domestic violence are around four times as high as the rates for non-abused women.[12]

- Research in the US has found that 30% of rape victims report experiencing at least one episode of major depression in their lives compared with only 10% of women who have never been affected by violent crime.[13]

- In one study, the rate of lifetime depression among childhood rape survivors was 52% compared to 27% among non-victims.[14]

- On average, at least two thirds of domestic violence survivors and women who have experienced sexual violence in childhood and/or as an adult report suffering from anxiety and a third have panic attacks.[15]

- Survivors of domestic violence are much more likely to experience post-traumatic stress disorder (PTSD) than people involved in serious car accidents.[16]

- One third of women attending A&E for self-harming have experiences of domestic violence.[17]

- Women who have experienced domestic or sexual violence are around four times more likely to think about suicide compared with the general female population.[18]

- Victims of domestic violence who experience sexual violence are five times more likely to attempt suicide than those who have not.[19]

- Survivors of childhood sexual abuse have also been shown to be at greater risk of problem alcohol use and eating disorders later in life.[20]

- Research has also found that the more abuse you experience, the greater the impact on your mental well-being.[21]

Sadly, however, mental health problems are often diagnosed without knowledge of or reference to any trauma. The dominant medical model of understanding mental distress means this connection frequently remains obscured and survivors are pathologised for the way they respond to trauma.

Not taking into account experiences of trauma when assessing and treating mental health problems can leave victims at risk of further harm from a perpetrator, as well as result in less effective interventions to manage their mental health.

4. Post-traumatic stress disorder

In addition to experiencing higher rates of depression and anxiety than the general population, survivors of domestic and sexual violence are also more likely to experience post-traumatic stress disorder (PTSD).

4.1 What is post-traumatic stress disorder?

Almost all people who go through a traumatic event will respond in some way to their experience. This reaction is typical of normal, healthy people who suffer from trauma involving physical injury or threat. About 30% of people who experience trauma will also experience PTSD.[22]

The diagnostic criteria for PTSD are:

- **Intrusion or flashbacks:** Recurring, distressing re-experiencing of past trauma in memories, dreams or reliving the abuse, as if it was happening all over again.

- **Avoidance** of memories, feelings or conversations associated with the trauma or general **numbing** (unable to remember important aspects of the abuse; loss of interest or involvement in life; feeling flat, empty, pessimistic about a future).

- **Arousal:** including difficulty falling or staying asleep; irritability or anger; difficulty concentrating; hyper-vigilance (being overly watchful); startled easily (jumpy).

In order to meet the clinical diagnosis of PTSD, these reactions must last for more than a month and cause significant distress or affect the person's ability to cope day to day.

In its presentation, PTSD appears to be quite cyclical, with patterns of alternating arousal and avoidance. As the cycle of PTSD continues

and becomes chronic, avoidance and withdrawal gain prominence, whilst symptoms of arousal and hypervigilence subside. As this happens, survivors may be given diagnoses of depression or somatisation disorder, amongst other things, and the role of trauma in the individual's presenting symptoms may be ignored.[23]

4.2 Rates of PTSD

For women and children, trauma that results from violence within intimate relationships can lead to more pronounced responses than traumatic events which are natural disasters or accidents:

- On average, 64% of abused women have PTSD, significantly more than lifetime prevalence of under 26% in the general population.[24]

- Reported rates of PTSD among rape survivors vary from approximately 30% to 65%, with the US National Women's Study reporting that almost one third of all rape victims develop PTSD.[25]

- In one study, women who reported childhood sexual abuse were five times more likely to be diagnosed with PTSD compared with non-victims.[26] Another study showed that the lifetime rate of a PTSD diagnosis was over three times greater among women who were raped in childhood compared with non-victimised women.[27]

- Research has found that survivors of domestic violence who were stalked or harassed by their (ex-)partner are twice as likely to experience hyperarousal symptoms than those were not.[28]

- Studies estimate that around 20% of military personnel who have seen combat experience PTSD.[29]

- It is estimated that less than 10% of survivors of serious car accidents develop post-traumatic stress symptoms.[30]

4.3 Complex PTSD

While post-traumatic stress is a normal and common reaction to violent crime and abuse involving threat of injury, not everyone experiences the same consequences: in type, severity, duration or frequency.

The following factors make a PTSD reaction especially severe, or more long-lasting:

- The trauma is caused by humans rather than by a natural disaster.
- The trauma was caused by a person known to the victim, rather than a stranger.
- The experience is personal and individual, rather than shared by many.
- There is continued contact with the perpetrator.
- The trauma being repeated rather than an isolated incident.
- The trauma occurs in a previously safe environment.
- There has been rape or sexual violence.
- There is little sympathetic social support.
- There is a history of previous abuse or violation e.g. in childhood.

Most of these factors apply to women experiencing domestic and sexual violence, so their post-traumatic stress reaction is likely to be more severe and to last longer. In particular, many women **remain in on-going danger,** experience **multiple incidents** of abuse as well as **secondary victimisation** through negative reactions from others. Many women are also effectively exiled from their communities, which further undermines their identity and support.

Judith Herman[31] believes domestic violence is more likely to be followed by complex PTSD and that it creates a spectrum of conditions rather than a single problem. **Complex PTSD** includes:

- Difficulties regulating emotion, including explosive anger or inability to feel anger, self-harm or suicidal ideas or behaviours, inhibited sexuality, persistent uneasiness.
- Changes in consciousness including loss of memory, numbing, feeling a sense of unreality, constantly thinking about the abuse, intrusive memories, flashbacks.

- Changes in view of self, including a sense of helplessness, shame, guilt, a sense of defilement/ violation or stigma, and complete difference from others (aloneness, feeling inhuman, belief no one can understand).

- Altered perception of perpetrator, including preoccupation with relationship, belief in their omnipresence and omnipotence, trauma-induced gratitude or dependency, sense of supernatural relationship and taking on the abuser's belief system.

- Altered relationships including isolation, difficulty in intimate or close relationships, distrust, repeated failures of self-protection, search for rescuer.

- Altered belief system, altered faith, hopelessness, despair.

4.4 Borderline personality disorders

The symptoms mentioned above largely mirror the diagnostic criteria for borderline personality disorder. There is increasing recognition within the field of mental health about the overlaps between these two diagnoses and how complex trauma stress may be misdiagnosed as borderline personality disorder.

Historically, the diagnosis of a borderline personality disorder has been stigmatising and also controversial, as it implies that an individual's personality is flawed. Individuals with these symptoms often find it difficult to engage with services and treatment and thus have a reputation for being problematic to treat.

Research has shown, however, that borderline personality disorder diagnoses are common among survivors of childhood sexual trauma who have been most severely impacted, such as those in high secure psychiatric hospitals.[32]

Multiple studies highlight the association between child abuse, including sexual, and borderline personality diagnoses, with some reporting over 90% of people diagnosed having suffered from some form of childhood abuse.[33] Childhood sexual trauma is also associated with other personality disorders, although individuals with

a borderline personality disorder report higher rates of sexual abuse compared with those with other personality disorder diagnoses.[34]

Borderline personality disorders are often diagnosed alongside other mental health problems, including depression, substance use, eating disorders and other personality disorders. There is evidence of high rates (60-70%) of co-morbid borderline personality disorders and PTSD.[35]

Whilst there is no definitive answer about the cause of borderline personality disorders, it is important to remember the association with experiences of trauma. This can inform how we respond to individuals who have the diagnosis and the treatment they are offered.

5. Trauma and the brain

There is increasing understanding about how the brain responds to life-threatening situations, and also manages and is impacted by trauma. This knowledge can provide some insight into some of the trauma responses that survivors display.

By including information about the impact of trauma on the brain, we do not wish to suggest all mental health problems have a biological cause. For survivors who may feel negatively about themselves for acting in a certain way, however, it can be beneficial to understand how the brain functions in the face of (repeated) threat.

5.1 Fight, flight, freeze, flop, friend

The amygdala is the part of the brain that is primarily focused on threats to safety. All information that enters the brain is scanned by the amygdala to detect any potential threat to our survival.

When the amygdala detects a potential source of harm, it responds incredibly fast, takes over the functioning of the brain and instinctively triggers our 'fight or flight response'.

Since coining the term 'fight or flight', researchers have noted three further automatic responses to extreme stress or threat: freeze, flop and friend.[36] It is important that survivors are aware that freezing, flopping, or befriending an attacker

can be instinctive responses and no less 'natural' than fighting or fleeing.

As the amygdala is geared towards immediate survival, it chooses the response that mostly likely means the individual remains alive and safe. If a strategy is successful, it will be reinforced in the brain and more likely to be used in future.

This means that survivors may become habituated to responding to threats in a way that may not seem appropriate. Furthermore, because the activation of the amygdala also reduces activity in other parts of the brain that are responsible for analysing and acting upon information, survivors of domestic and sexual violence may become even more dependent on the reflexive responses of the amygdala.[37]

When we face very real dangers to our physical survival, the 'fight and flight response' is invaluable. When all situations involving extreme stress trigger similar responses, survivors' long-term well-being can be sacrificed for immediate survival.

5.2 Heightened sensitivity to threat

It is understandable to most that survivors of domestic and sexual violence may be particularly vigilant and aware of potential threat for some time after their experience(s) of trauma. For some survivors, this heightened sensitivity may become chronic – either because of a very real on-going threat,or also as a result of how trauma impacts on the brain.

Trauma, particularly in childhood, can dramatically increase the number of stimuli that our bodies perceive as stressors. Survivors can experience a gradual lowering of the threshold for stimulation, meaning that they are increasingly sensitive to all kinds of stimuli that may be completely unrelated to the original trauma. This increased sensitivity, called 'kindling', can be a result of certain pathways in the brain, including the amygdala, becoming sensitised and starting to fire spontaneously, sometimes even without an external stimulus.

5.3 Cognitive functioning

In a 'fight or flight' state, the amygdala temporarily takes over the management of the brain. In doing so, other parts of the brain shut down which inhibits the cognitive processes that are needed for processing information, planning and taking action.

In cases of repeated trauma, or where survivors experience chronic activation of the amygdala and other systems that respond to stress, this may provide an explanation (at least partially) for the noted difficulties some survivors have with what is called 'self-regulation'. This refers to the internal organising functions that are essential to problem solving, processing information, communication skills, and further higher levels of processing such as strategic planning and abstract reasoning. Impaired self-regulation is considered by some to be the most-far reaching effect of trauma,[38] and goes some way to explain why survivors may struggle to make decisions or plan and carry out actions.

5.4 Impact on memory

Survivors of domestic and sexual violence can struggle with memories of traumatic experiences – either they cannot recall, cannot recall clearly or keep recalling the event. This can be, at least partially, a result of how the brain is affected by trauma.

When triggered, the amygdala sends out distress signals to the thalamus, which responds by releasing stress hormones such as adrenaline. High levels of hormones, like adrenaline, can stop the hippocampus – a part of the brain that processes memories – from working properly. This can be similar to the hippocampus 'blowing a fuse', meaning that memories of the trauma cannot be processed, which in turn causes flashbacks and nightmares. If the stress goes away and the adrenaline levels return to normal, the brain is able to repair the damage. The memories can be processed and the flashbacks and nightmares will gradually subside.

The impaired functioning of the hippocampus and the prefrontal cortex may also explain why trauma-based memories as vague,

fragmented and disorganised in terms of time.

6. Using substances to cope

How do you cope with stress, anxiety, feeling low, after a hard day at work, after an argument with your manager, your partner or your children?

We all have strategies for regulating our sense of inner and outer security. We may avoid the issue, deny what's going on, we may minimise the urgency or importance of the matter, we may become defensive, angry or find fault with others as a type of attacking strategy. Some of us may hurt or attack ourselves – we may punish ourselves internally in our head, physically in the gym, by not eating properly or by injuring ourselves.

And, of course, we may use substances, including alcohol, prescribed medication and other drugs. Survivors of domestic and sexual violence do exactly the same to manage their responses to the trauma they have experienced.

6.1 Substance use in the UK

'Substances' are used widely in our society. Most adults in the UK use the stimulant caffeine, through consuming drinks such as tea, coffee and soft drinks, and foods such as chocolate.

Over a quarter of adults in the UK consume alcohol in a way that is potentially or actually harmful to their health, and 4% of adults are dependent on alcohol.[39]

Over a third (36.3%) of the population will use illicit drugs at least once in their lifetime, with 3.4% becoming drug dependent.[40] Cannabis is the most commonly used illicit drug in England.

6.2 Survivors' use of substances

Rates of substance use among survivors of domestic and sexual violence are considerably higher than in the general population:

- Women survivors of childhood sexual abuse are three times more likely to use drugs and/or alcohol problematically than women who have not been abused.[41]

- The prevalence of childhood sexual abuse amongst problematic substance users is around twice as high as in the general population.[42]

- A US study of 'female alcoholic patients' found that two thirds of women had suffered partner abuse in the previous 12 months.[43]

- Another US study reports that 60% of women accessing drug or alcohol services reported current or past domestic abuse.[44]

- 25-75% of people who have survived abusive or violent traumatic experiences report problematic alcohol use, compared with 10-30% of people who experience accident-, illness-, or disaster-related trauma.[45]

- Compared with adolescents who have not been sexually assaulted, adolescent sexual assault victims are 4.5 times more likely to experience alcohol abuse or dependence, four times more likely to experience marijuana abuse or dependence, and nine times more likely to experience hard drug abuse or dependence.[46]

6.3 Self-medication

The co-existence of mental health and substance use problems, often referred to as 'dual diagnosis', is relatively common. Three-quarters (74.5%) of users of drug services reported experiencing any type of mental health problems, and it is estimated that a third of mental health service users have a substance use problem.[47]

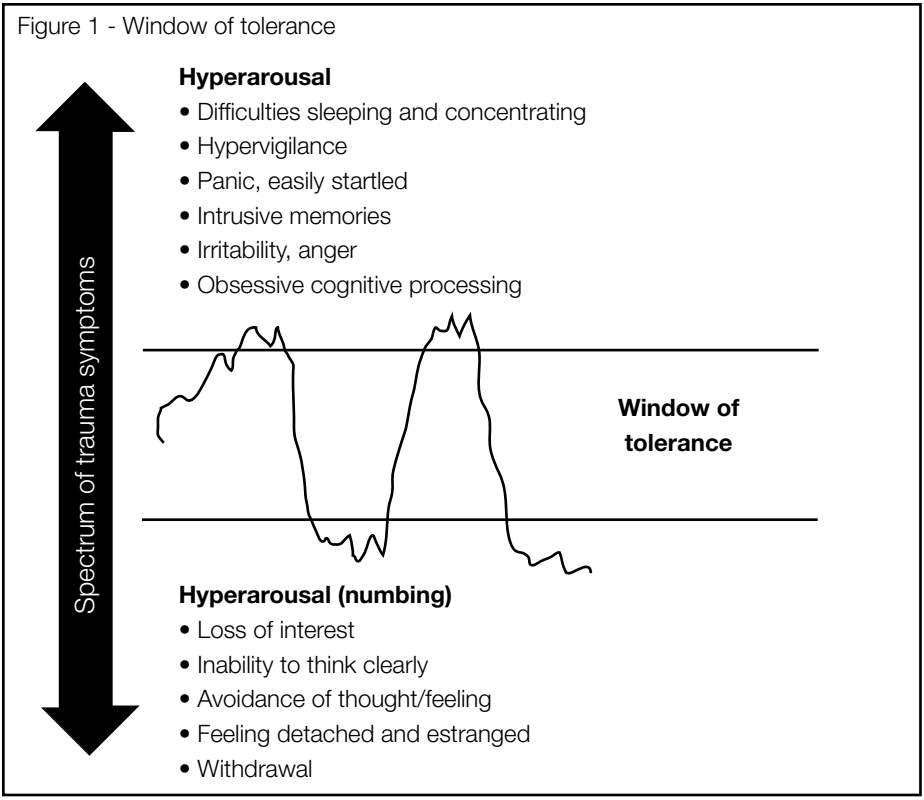
There is some consensus that mental health problems often precede substance use, and that many people use different substances to manage the symptoms of mental ill-health. In terms of managing trauma responses, substances are used in different ways.

One of the main difficulties with trauma responses is that they frequently fall outside what is called the 'window of tolerance',[48] a zone of emotional arousal that is optimal for well-being and effective functioning.

People who have been affected by a traumatic event can experience too much arousal (hyperarousal) or too little arousal (hypoarousal) and often oscillate between these two extremes (see figure 1).[49]

Depressants (such as alcohol, cannabis, heroin and other opiates, benzodiazepines) can be effective, at least in the short-term, in managing **hyperarousal.** Depressants slow down the central nervous system and suppress neural activity in the brain. As such they mirror the symptoms of numbing. For people who have experienced trauma and are unable spontaneously dissociate, they may use alcohol or other depressants to achieve this effect. Depressants may also enable survivors to function by

Figure 1 - Window of tolerance



dampening down anxiety, reducing sensitivity to stimuli, and helping (temporarily) with sleep.

"Research on survivors of domestic violence found that two-thirds experienced problematic substance use as a consequence of the abuse. The primary reasons given were to dull the physical and emotional pain of physical violence, to escape reality and to simply survive the abuse." [50]

Depressants may also help manage painful and overwhelming feelings such as sadness, fear and shame. People who have experienced trauma, particularly in childhood and adolescence, may not to be able to self-soothe, i.e. calm themselves down and regulate their emotions. They may take depressants to cope with these emotions or to shut them out for a short time.

Conversely, **stimulants** (cocaine, speed/amphetamines, crystal meth, ecstasy) may be used by people experiencing **hypoarousal.** Stimulants speed up the central nervous system and increase activity in the brain, so therefore may be useful to survivors who suffer from depression or feeling completely numb or flat.

People with PTSD can also have trouble experiencing pleasure engaging in ordinary tasks, have difficulty staying focused until a job is finished, and often find it difficult collaborating with others in situations that require maintaining multiple perspectives. Using stimulants can help someone focus and increase pleasure in activities.

6.4 The problem with problematic substance use

"There is no doubt that alcohol misuse is associated with a wide range of problems, including physical health problems such as cancer and heart disease; offending behaviours, not least domestic violence; suicide and deliberate self-harm; child abuse and child neglect; mental health problems which co-exist with alcohol misuse; and social problems such as homelessness." [51]

In the short term, substances can help reduce feelings of being 'wound up' and may temporarily decrease the frequency and severity

of frightening nightmares. It may also, however, increase irritability and hypervigilence. Research shows that alcohol use, particularly heavy alcohol consumption, can result in the chronic activation of stress responses that mirror trauma responses and thus increase psychological distress rather than reducing it.[52]

Alcohol consumption can also impede a survivor's ability to manage future stressful life events. Research has shown that stressful situations are more strongly associated with depressive symptoms among heavy drinkers than in moderate drinkers.[53]

Experiencing post-traumatic stress and problematic substance use can also lead to other psychological problems. Research has found that women who have been diagnosed with PTSD and a substance use disorder appear to present with a more severe clinical profile than those with only one diagnosis. They are more likely to use cocaine and opiates (rather than alcohol and cannabis which are more widely used) and report extremely high rates of co-morbid (co-existing) anxiety and mood disorders.[54]

Both substance use and mental health problems (regardless of the cause) are also, for various reasons, further associated with physical ill-health, unemployment, poverty, homelessness and vulnerability to further abuse:

- Serious mental illness influences the likelihood of being in unsafe environments, and increases vulnerability to violent victimisation.[55]

- Multiple studies with female substance users demonstrate high rates of partner violence, physical assault and stranger rape; the majority of women diagnosed with problematic substance use and PTSD are even more vulnerable to repeated violence and abuse throughout their lives.[56]

- Describing the incidence and experience of rape among women in residential drug treatment, Teets found that 73% of women in her study had experienced sexual trauma, and that these traumas could be classified into five categories: raped while in the context of using, while too high to resist, while prostituting, by a significant other, and by a family

member.[57] 35% of the rapists were described as friends of the survivor with whom they had been using drugs.

- Homeless women, including those living in hostels and sleeping rough, are vulnerable to physical violence from family members, acquaintances, as well as other homeless people and the general public. They also frequently report sexual assault, most commonly perpetrated by someone know to them.[58]

- Substance use is commonplace among women involved in prostitution: in one study 87% of women interviewed used heroin.[59] More than half the women involved in prostitution, both on- and off-street, have been raped or seriously assaulted and at least 75% have been physically assaulted by a pimp or punter.[60]

Experiencing domestic and sexual violence, mental ill-health and/or problematic substance use can leave survivors in a cycle of being vulnerable and victimised, which can lead to increased problems with their mental well-being and increased use of substances to cope.

"If you come across someone who has no understanding of any of it, it makes you feel like a piece of shit, it puts you back to square one"

Survivor's voice