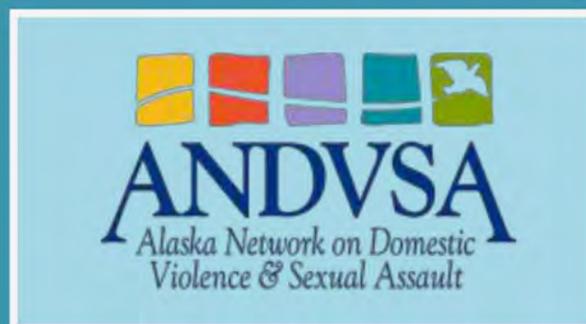




REAL TOOLS: RESPONDING TO MULTI-ABUSE TRAUMA

A TOOL KIT TO HELP ADVOCATES AND COMMUNITY PARTNERS
BETTER SERVE PEOPLE WITH MULTIPLE ISSUES

BY DEBI S. EDMUND, M.A., LPC
AND PATRICIA J. BLAND, M.A., CDP



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DEDICATION

Wilma Louise Bennett

We dedicate this edition of *Real Tools* in memory of Wilma Louise Bennett. Wilma's Tlingit name was "Taats" and she was Ishktaan from the "Pool-in-the-River" house of Taku. Wilma served as a strong advocate for recovering women and survivors of domestic violence, sexual assault and child sexual abuse during her nearly five years with the Training Project at the Alaska Network on Domestic Violence and Sexual Assault.

Wilma (pictured here far right with Lindsee Acton) was a beloved member of the Juneau community and a vital force behind the development of the *Real Tools* manual. During her tenure at the Network, Wilma never wavered in her commitment to people who experienced harm at the hands of others and she worked hard to reduce barriers for women and children impacted by multiple forms of abuse.



Throughout Wilma's long illness she shared her experience, faith and hope with all of us at the Network. Wilma lived every moment. She loved the glacier, her God and her family. She found humor in everything, even during her illness. Wilma was truly the 'Boss' and involved with organizing *Real Tools* (and everything else) until we lost her on January 29, 2011. No doubt she is checking for typos in the sky and putting in a good word to the Angels for the people we serve.

Wilma was born on Nov. 18, 1942, in Juneau. Her parents were William and Beatrice Stoddard. Her brother, Bill, lives in Washington state. Wilma met her true love, Robert J. Bennett, at the Juneau Teen Center in 1964. They were married in 1981. On Sept. 4, 2010, Wilma and Bob celebrated 29 years of marriage. Wilma was loved by all and will be missed by her family, her friends and all of us at the Network.

Ldakát wuháanch, itusixán.

Gunalchéesh yá haa t'éit' yeeynaagí.

Tsu yéi ikkwusatéen.

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The Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) offers sincere appreciation and respect to our member programs in Alaska who daily seek to help the people in our communities alleviate and overcome the impact of violence, abuse, trauma and co-occurring issues. We thank you for your tireless efforts and ongoing commitment to safety, sobriety, wellness and justice.

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We thank you, the readers and users of this manual, for taking the time to review materials addressing the needs of underserved individuals with multiple abuse issues. People experiencing multiple forms of abuse are often invisible. Your advocacy on their behalf is critical. We thank you for your commitment to reducing barriers for survivors of multi-abuse trauma and we thank you for your willingness to provide services geared towards ending oppression of all kinds.

But most of all, thanks to everyone seeking safety, sobriety, wellness and justice who shares their journey to freedom with others, one person and one group at a time. You are our inspiration.

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OVERVIEW:

MULTI-ABUSE TRAUMA AND ADVOCATE RESPONSE

PREFACE

Advocates and other social service providers who have been in the field for any length of time are all too familiar with the revolving door syndrome. That is, we witness the system-wide oppression of a small but growing percentage of people seeking our services who are revolving through the social service system over and over again, going from one agency to the next, sometimes for years. They experience multiple barriers, multiple forms of abuse (including provider prejudice) and are often unable to get the right kind of help they need to fully address or resolve their issues.

During an intake assessment, or in the course of an advocacy or counseling relationship, we often uncover a complex, interconnected array of issues besides the one our particular program or agency is equipped to handle. Many of the problems are long-standing, often dating back to childhood. For example:

- An individual seeking help from a domestic violence program also struggles with alcohol and drug dependence, complex trauma stemming from years of childhood sexual abuse, bipolar disorder, homelessness, and trouble finding employment due to a drug-related conviction.
- An individual seeking help from a drug and alcohol treatment center also struggles with attention deficit hyperactivity disorder (ADHD), depression and anxiety, unresolved trauma from childhood physical and sexual abuse, and difficulty participating fully in treatment due to interference and sabotage from an abusive partner.

The sheer number – as well as complexity and seeming intractability – of the individual’s issues may leave us feeling bewildered, overwhelmed, or even incompetent. Where do we begin in our efforts to provide advocacy? How do we help this person unravel all these problems in an empowering way?

When multiple barriers exist, advocates should consider the possibility that the person seeking our help is a survivor of *multi-abuse trauma*.

What is multi-abuse trauma?

Multi-abuse trauma is a term used by some advocates for survivors of domestic violence and sexual assault when an individual is impacted by multiple co-occurring issues that negatively affect safety, health or well-being (Slater, 1994). Examples include unresolved childhood trauma, substance abuse or dependence, psychiatric issues, disabilities, untreated or chronic medical conditions, social oppression, intergenerational grief or historical trauma, poverty, homelessness, exploitation by the sex industry, and incarceration.

Multi-abuse trauma often involves both *active* forms of abuse and *coping* forms of abuse. *Active* forms of abuse include the kinds of harm one human being does to another, such as sexual assault, domestic violence, child abuse or neglect, and emotional or psychological abuse. *Coping* forms of abuse are the methods victims of active abuse may use to cope with their situation, such as substance abuse, compulsive eating, bingeing and purging, and self-mutilation (cutting).

An individual's situation may be complicated by co-occurring issues such as disabilities, medical conditions or psychiatric issues. These issues may or may not be a direct result of trauma, but often complicate efforts to address it.

An additional layer of trauma may further exacerbate the situation. Besides the stigma surrounding various kinds of trauma, an individual may face societal oppression due to misconceptions about race or ethnicity, age, social class, disabilities, sexual orientation or immigration status. This trauma can also be passed from one generation to the next in the form of intergenerational grief and historical trauma.

Some coping forms of abuse may lead to further traumatic experiences, such as homelessness or incarceration, and may include the development of long-term consequences for an individual's children as well (Felitti et al., 1998).

Finally, an individual may experience trauma from the very social services system that was designed to help people. Individuals with multiple issues often face considerable barriers when trying to get help, and the inability to access appropriate services creates its own stress. The system itself thus adds to, rather than alleviates, their problems.

What does multi-abuse trauma look like?

Perhaps the best way to illustrate multi-abuse trauma is to give some examples.

Sara grew up watching her father perpetrate domestic violence against her mother. He started raping Sara before she was three years old. The abuse continued throughout her childhood, and she was forced into prostitution at age 9. When she was a teenager, she was gang-raped by a brother's friends, and she continued to suffer sexual assaults into her young adulthood. Her parents' immigrant status contributed to her family's isolation. Her father did not speak English and had difficulty holding down a job, and the family lived in poverty. Sara coped with the multiple childhood traumas by dissociating, and as an adult, she was diagnosed with dissociative identity disorder. She also suffers from fibromyalgia, which she believes is her body's long-term reaction to the ongoing, repeated abuse she endured as a child.*

Edie grew up with ADHD and mild autism, which people often responded to by shunning her. Peers at school bullied her physically and psychologically, and beginning about age 10, sexually as well. Some adults accused her of being lazy and oppositional. Desperate to fit in with her peers, Edie began using alcohol and drugs when she was a*

teenager. This helped her feel more comfortable in a group of people for the first time in her life, and her alcohol and drug use increased until she became addicted. She married a man who turned out to be abusive. He used both her addiction and the “oddness” stemming from her developmental issues to convince her that no one else liked her and no other man would have her. Edie began to suffer from bouts of depression, and her addiction to alcohol and drugs became more severe. By the time she began seeking help from the social service system, she was coping with several issues: a developmental disability, substance use disorder, an abusive marriage, depression and anxiety, and complex trauma from the childhood abuse.

Mary, who is of Alaska Native ancestry, was removed from her family by government officials when she was 12 years old and placed in a boarding school with 6,000 students several hundred miles away from the small rural village where she grew up. The purpose of the boarding school was to force the assimilation of Alaska Native children, and replace ancestral traditions, customs and values with those of the dominant culture. Mary’s parents were given no choice in the matter – they were told they would go to jail if they didn’t allow the government to place her at the boarding school. As an adult, Mary endured several years of severe domestic violence. She coped with both the childhood boarding school trauma and the adult domestic violence by shutting down her emotions because she did not feel as if she could talk about her experiences with anyone. She began to suffer from a variety of physical illnesses and nearly died from pneumonia before she finally reached out for help.*

* Names have been changed.

Implications of multi-abuse trauma for providers

Western thought is often based on a linear or atomistic model of problem-solving – that is, we narrowly focus on one issue at a time – and this model is often reflected in the dominant culture’s system of social service delivery. A domestic violence shelter focuses on domestic violence. A sexual assault program focuses on sexual assault. A drug and alcohol treatment center focuses on substance use disorders. A mental health center focuses on psychiatric issues. A homeless shelter focuses on helping people find housing. And so on.

Sometimes this single-focus model works exactly the way it’s supposed to:

- A woman with a well-paying job, a stable life and no prior history of trauma decides to stop seeing a man she has been dating because of his controlling behavior. He does not accept her decision and begins stalking her. She understands the problem is not her fault. She seeks help from a domestic violence program to get an order of protection. Staff members work with her on safety planning and accompany her to court. The order of protection is served and, thankfully, the stalking stops. At this point, the woman has gotten what she needs from the program and moves on with her life.
- An otherwise healthy man goes to a walk-in clinic with a sore throat and a fever. The

doctor diagnoses strep throat and prescribes a round of antibiotics. The man gets extra rest, he takes his medication as prescribed, and the problem goes away in a few days.

- A woman begins seeing a therapist because she feels depressed. Over the course of 10 sessions, the therapist helps her identify and sort through her feelings about her recent divorce. The woman tries some of the therapist's suggestions and her mild depression begins to lift, even without medication.

A survivor of multi-abuse trauma shares how the cumulative effect of domestic violence on top of her history of trauma affected her:

“How did it affect me? In every way possible. It interfered with my sobriety. I ended up relapsing after many years of being clean and sober. I ended up losing my career. I lost the place where I lived, and became homeless. I was physically injured with permanent effects. My ability to form relationships with people suffered. My gosh, I already had trust issues. I still do, and I’m 55 years old.”

However, this single-focus model does not begin to address the complexity of the situations facing people with multi-abuse trauma issues, who are often forced to negotiate a hopelessly fragmented system and obtain services from multiple sources in order to get their needs met.

The following hypothetical example illustrates the dilemma:

Jane has recently been released from prison, where she served a two-year sentence for a drug-related offense. Upon her release, she returns to an abusive partner, because she has nowhere else to go. Her children have trouble adjusting, first to her extended absence, then her return. At the prison she was being treated for bipolar disorder, but she has run out of medication and cannot afford to refill her prescription. She is

having trouble finding employment because of her conviction record. As she struggles to stay off illegal drugs, she also is beginning to have intrusive memories stemming from a history of child physical and sexual abuse.

If Jane lives in an urban area, she may be receiving services from any or all of the following providers simultaneously:

- *An advocate for domestic violence and childhood sexual abuse issues.* In some communities, an individual dealing with both domestic violence and childhood sexual abuse will have to seek appropriate services through two separate agencies.
- *A substance abuse counselor for her alcohol and drug dependence.* She may also choose or be required to attend 12-Step group meetings in the community.

- *A therapist for mental health concerns.* The therapist may offer counseling, then refer her to a psychiatrist for medication. Her children may be referred to a child welfare caseworker, a school counselor, or a separate program within the mental health agency for their issues.
- *One or more caseworkers for public assistance.* An individual applying for Temporary Assistance for Needy Families (TANF), food stamps and child care assistance may be required to register through three separate systems even if these benefits are all handled by the same government agency.
- *A parole or probation officer.* Prison policies in some states have prohibited social service providers who serve individuals while they are incarcerated from providing services to the same individuals once they are released.

If Jane lives in a rural community or an isolated, remote village, some or all of these needed services may be difficult to access or even nonexistent. If she is indeed able to receive services, she may hear conflicting messages and find herself overwhelmed.

Rationale for developing this manual

The primary goal of *Real Tools: Responding to Multi-Abuse Trauma* is to help advocates and other service providers understand the safety, autonomy, recovery, wellness and justice needs of people who are impacted by multiple co-occurring issues. The manual is designed to go beyond theory to give advocates and their community partners practical tools to address those needs.

Because the social service system is so fragmented, cooperation between providers from a wide variety of disciplines is essential. The authors hope the manual can serve as a bridge between advocates and other service providers so that individuals with multi-abuse trauma issues can get their needs met, no matter where they enter the social service system.

Overall manual format and components

This manual was created with maximum user-friendliness in mind. The authors hope the manual will be widely used for training advocates and other service providers, creating support groups for individuals coping with multi-abuse trauma issues, and educating and advocating in the community.

The first section, “Multiple Layers of Trauma,” presents an overview of multi-abuse trauma, and discusses the special safety, recovery and wellness issues involved when individuals are coping with co-occurring problems in addition to interpersonal violence.

The section “How Should Advocates Respond?” offers guidelines for empowering individuals with multi-abuse trauma issues, along with special issues to be aware of. Also

included are tips for creating a welcoming environment and gaining the trust of the people you serve, as well as a discussion of practices that may inadvertently re-traumatize survivors.

“A Closer Look at Individual Issues” explores in more detail several co-occurring issues that may be involved in multi-abuse trauma. These include complex trauma from past abuse, substance abuse or dependence, psychiatric issues, disabilities, social oppression, historical trauma and intergenerational grief, poverty, homelessness, exploitation by the sex industry and incarceration.

The section “Working with Other Providers” offers tips for building the alliances that are such a necessary component of adequately serving individuals with multi-abuse trauma issues. This section also discusses the philosophies and priorities of other providers, including substance abuse counselors, mental health providers, indigenous providers, child welfare caseworkers and criminal justice personnel.

“Self-Care and a Healthy Workplace” discusses the importance of maintaining a healthy work environment and addressing the risk factors for burnout and vicarious trauma. Because providers who work extensively with trauma issues are at high risk for vicarious trauma due to the nature of the work, this section emphasizes that self-care is not a selfish indulgence, but rather is essential to the individual provider’s health and to the welfare of the people served.

The “Advocate’s Tool Kit” contains practical suggestions and tools for assessing the people we serve for trauma/co-occurring issues, training advocates and other providers, engaging in community education and advocacy, and creating support groups for people with multiple issues. Included are guidelines, suggested training or support group topics and formats, and handouts that can be photocopied.

As part of the research for this manual, the authors interviewed several advocates and other providers who work extensively with people who have multiple issues. The authors also interviewed several people who have survived and transcended their experiences of multi-abuse trauma. Vignettes or “survivor stories” based on these interviews are sprinkled throughout the manual to help illustrate the concepts presented. To protect the confidentiality of the survivors we interviewed, no real names have been used.

A word about language

Because *Real Tools: Responding to Multi-Abuse Trauma* is intended for use as an interdisciplinary cross-training tool, the authors have used language designed to make the information accessible to providers across disciplines. With this in mind:

- We have attempted to avoid the use of jargon, and all acronyms are spelled out the first time they are used in a new section of the manual. We also have included an appendix with definitions of terms commonly used within various disciplines such as mental health, child welfare, criminal justice, etc.

- We use generic terms such as *service providers* rather than the unwieldy “advocates, counselors, caseworkers, therapists, social workers or other providers.”
- We have elected to use “person-first” language throughout the manual whenever we refer to people who use our services. In addition to humanizing the people we serve, we hope this can alleviate possible conflict during interdisciplinary cross-training between advocates who prefer terms such as “program participant” and other service providers who prefer terms such as “client” or “patient” or “consumer.”

Also, we refer in this manual to both *multi-abuse trauma* and *complex trauma*. While the two terms are related, they are not identical.

Multi-abuse trauma is a term used by some advocates who serve survivors of domestic violence and sexual assault. It refers to the multiple layers of trauma and oppression that may be experienced when an individual is impacted by multiple co-occurring issues that negatively affect safety, health or well-being. While advocates are not therapists or clinicians, the role of the advocate includes identifying barriers to safety, autonomy, services and justice. When multiple barriers exist, advocates should consider the possibility that the person seeking our help is a survivor of *multi-abuse trauma*. The term *multi-abuse trauma* describes not what is wrong with a person but acknowledges *the many forms of harm that have happened* to an individual. This framework makes it possible to understand behaviors that on the surface don’t make sense to us but make sense to those for whom we provide advocacy. It also provides a framework to explore multiple options with the people we serve.

A survivor of multi-abuse trauma describes the sense of frustration she felt when she was forced to seek services from multiple providers:

“I couldn’t seem to find a provider who would hear my entire story. It was like, ‘We can deal with this little piece of you, but please don’t bring in all these other things, because it’s too complicated.’ Well, by golly, people are complicated. If you’re trying to get what you need from the social service system, you can begin to feel like you’re being cut into little pieces.”

Complex trauma is a term used by some mental health professionals to refer to a condition that can result from prolonged and repeated abuse, especially if the abuse began in early childhood or came from multiple sources (Herman, 1997, 2009; Warshaw, 2010). Complex trauma involves traumatic stressors that are repetitive or prolonged; involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults; occur at developmentally vulnerable times in the victim’s life, such as early childhood; and have great potential to severely compromise a child’s development (Courtois and Ford, 2009). Complex trauma is also referred to by some mental health professionals as *complex traumatic stress* or *complex psychological trauma* (Courtois &

Ford, 2009) and *complex posttraumatic stress disorder* (Herman, 1997, 2009).

People experiencing *multi-abuse trauma* may or may not have a clinical diagnosis such as *post-traumatic stress disorder* or *complex trauma*. The term multi-abuse trauma is not and should never be used to label, diagnose, pathologize or judge a person receiving our services. Rather, we acknowledge and validate survivors' experience. As advocates, we bear witness to the harm that has been done, listen, believe and connect.

About copyright

Feel free to photocopy as many handouts from *Real Tools* as needed for educational purposes, but please make sure the copyright notices are included on each handout. The Power and Control Wheels appear in this manual courtesy of the National Center on Domestic and Sexual Violence, which credits the Domestic Abuse Intervention Project in Duluth, MN, for inspiring the Wheels. Group facilitators and trainers may photocopy as many of the Wheels as they wish for educational use. However, the National Center requests that copyright notices and Web site information (where applicable) appear on each of these handouts. The National Center also requests that the Wheels not be altered in any way.

MULTIPLE LAYERS OF TRAUMA

While sexual assault and domestic violence can be traumatic for anyone who experiences them, some survivors find their experience of trauma compounded in a number of significant ways – many of which “add insult to injury” and make safety and healing more complicated (Herman, 1997; Courtois & Ford, 2009; Warshaw, 2010).

Multi-abuse trauma is a term used by victims’ advocates when an individual is impacted by multiple co-occurring issues that negatively affect safety, health or well-being (Slater, 1994). Survivors of multi-abuse trauma who come to domestic violence shelters or sexual assault centers are coping with other issues besides interpersonal violence.

Examples of co-occurring issues include, but are not limited to: unresolved trauma from childhood sexual abuse, physical abuse or neglect; substance use disorders; psychiatric issues; disabilities; chronic or untreated medical conditions; growing up in a home where domestic violence or active substance abuse was present; growing up or currently living in a dangerous neighborhood; societal oppression; historical trauma or intergenerational grief; poverty; homelessness; and incarceration.

“It’s rare that I see someone who is not affected by more than one issue,” says Karen Foley, a behavioral health specialist and intensive case manager at Pacific Treatment Alternatives Safe Babies/Safe Moms program in Seattle, WA. “The majority of the people I work with are affected by multiple issues. That makes getting safe, sober and stable even more difficult” (Foley, 2010).

Multi-abuse trauma often involves both *active* forms of abuse and *coping* forms of abuse. *Active* forms of abuse include the kinds of harm that one human being does to another, while *coping* forms of abuse are the methods that victims of active abuse may use to cope with their situation.

Examples of *active abuse* include sexual assault; domestic violence; child sexual abuse, physical abuse or neglect; peer bullying; emotional or psychological abuse; and physical violence. On a societal level, examples of active abuse include sexism, racism, classism, ableism, heterosexism and other forms of prejudice and discrimination. At its most extreme, societal abuse can take the form of human trafficking, forced dislocation and genocide. On both the individual and societal level, active abuse also tends to include the denial of victims’ pain and suffering, as well as blaming victims for abuses committed against them.

Examples of *coping abuse* range from substance abuse to compulsive eating, bingeing and purging, compulsive spending or gambling, self-mutilation (cutting), and suicide attempts. Coping abuses such as illicit drug use may lead to additional coping abuses such as theft or engagement in commercial sex to support an addiction. These in turn may lead to further traumatic experiences, such as increased risk of experiencing interpersonal

violence, sexually transmitted infections, homelessness or incarceration.

An individual may experience co-occurring psychiatric or other disabilities or experience a medical condition that impacts options. These issues may or may not be a direct result of trauma, but they often complicate efforts to address it.

When traumas accumulate over time, they may be associated with more severe and complex psychological reactions (Briere & Spinazzola, 2009; Brodland, 2010). Such experiences not only can produce long-term consequences themselves, but they are also risk factors for re-victimization in the future and for responding to later traumas with more extreme symptoms (Herman, 1997). Trauma may also be intensified by environmental variables, such as inadequate social support and stigma associated with certain traumas. A survivor of multi-abuse trauma shares:

“Addiction, depression and sexual assault when I was a teenager were kind of like the foundation for the several years of abuse that followed. I think it sort of conditioned me to some degree for domestic violence. Because I was addicted, I already blamed myself for the abuse I’d gotten, so it was real easy for me to continue blaming myself when I had a partner who did the same thing. I got sober, and after 10 years of domestic violence or thereabouts, I got out of that relationship, had started seeing a counselor and then was assaulted. I was with a guy I had just gone out with a couple of times, and he assaulted me pretty badly. I had a breakdown. It was the accumulation – cumulative effect – of all this trauma. I went from being a college educated professional person to having severe depression, suicidal ideation with a plan, and they put me on heavy medication.”

Does interpersonal violence cause co-occurring issues?

Both service providers and the people who seek their help are often confused about cause and effect when an individual struggles with multiple issues. To what extent does the experience of interpersonal violence contribute to mental health issues, substance use disorders, homelessness or other issues? Do these issues make a person more vulnerable to interpersonal violence?

About one in three girls and one in six boys are sexually abused before the age of 18. Both female and male survivors have been found to suffer long-term effects from such abuse, including more suicide attempts, alcohol and drug problems, psychiatric issues and learning disabilities – problems which often persist into adulthood (ICASA, 2001).

Depression, post-traumatic stress disorder, anxiety and panic disorder are common among people seeking services from domestic violence shelters (Warshaw et. al., 2003). However, some experts believe that many behaviors and responses seen as “symptoms” by service providers are directly related to traumatic experiences that can cause mental health, substance abuse and physical health concerns (NCTIC, n.d.). Shirley Moses, Shelter Manager at Alaska Native Women’s Coalition in Fairbanks, AK, believes survivors of sexual assault or domestic violence are often misdiagnosed as having mental

health or psychiatric disorders, because the symptoms of trauma can masquerade as mental illness. She says mental health problems can also be “situational,” brought on by domestic violence or sexual assault, and other traumas:

“You might see someone who is losing her kids because she is sleeping half the day or she’s not able to cope anymore. She’s closing down, and they are thinking she’s mentally ill or she’s not trying to take care of herself or she’s not able to provide. And they don’t look at, why is she doing this?” (Moses, 2010)

The Women’s Action Alliance’s experience with a domestic violence shelter program over a fifteen-month period indicated 60-75% of the women seeking shelter services had developed problems with their original coping mechanism, alcohol and drugs (Roth, 1991). The Minnesota Coalition for Battered Women (1992) notes abused women may use alcohol or drugs for a variety of reasons, including coercion by an abusive partner, substance dependence, cultural oppression, over-prescription of psychotropic medication or, for women recently leaving a battering relationship, a new sense of freedom.

A survivor of multi-abuse trauma shares how she often blamed herself for violence:

“Because I was addicted, I already blamed myself for the sexual assault that happened when I was in my teens, so it was real easy for me to continue blaming myself when I had a partner who abused me as well.”

Domestic violence and poverty also are interwoven, says Jill Davies in a policy and practice paper *Policy Blueprint on Domestic Violence and Poverty*:

“Efforts to escape violence can have devastating economic impacts. Leaving a relationship might mean a woman will lose her job, housing, health care, child care, or access to the partner’s income. Often, criminal and civil legal remedies are necessary to safely leave a relationship. Criminal remedies typically have no monetary cost to the victim, but may take time away from work or job training, sometimes resulting in lost wages or loss of employment. The pursuit of civil legal strategies, such as divorce or custody actions, often drains family financial resources. Unable to afford litigation, some battered women concede financial and property demands in order to settle the case, further undermining their families’ security” (Davies, n.d.).

Domestic and sexual violence can push victims into a cycle of poverty. Experiencing interpersonal violence can lead to job loss, poor health, and homelessness. It is estimated that victims of intimate partner violence collectively lose almost 8 million days of paid work each year because of the violence perpetrated against them by current or former partners or dates (Cawthorne, 2008).

TRAUMA AND CO-OCCURRING ISSUES

Trauma is often the common thread or common denominator running through a variety of co-occurring issues, ranging from mental health concerns to substance abuse, poverty, exploitation by the sex industry, homelessness and incarceration. A look at some statistics provides examples of how trauma is involved in many of the current problems faced by people seeking help from social service agencies, especially people who are struggling with multiple issues simultaneously:

- **Substance abuse.** Preliminary data from a National Institute on Drug Abuse study noted 90 percent of women in drug treatment had experienced domestic violence from a partner during their lifetime (Miller, 1994). As many as 74 percent of women in substance abuse treatment have experienced sexual abuse (Kubbs, 2000).
- **Mental health.** As many as 90 percent of people who have severe psychiatric symptoms are survivors of at least one incident of trauma during their lifetimes (Akers et. al., 2007). Studies have found that up to 53 percent of people who seek services from public mental health centers report childhood sexual or physical abuse (Huckshorn, 2004). In one study, of the 90 percent of people receiving public mental health services who had been exposed to trauma, most had multiple experiences of trauma (Huckshorn, 2004).
- **Disabilities.** A person with a disability – regardless of age, socioeconomic status, race, ethnicity or sexual orientation – is twice as likely to be a victim of abuse than a person without a disability (Wayne State University, 2002). Among adults with developmental disabilities, as many as 83 percent of women and 32 percent of men have been victims of sexual assault (ICASA, 2001). In addition to abuse by family members or intimate partners, people with disabilities are at risk for abuse by attendants or health care providers. They are also more likely to experience a longer duration of abuse than people without disabilities (Young et. al, 1997). Street crime is a more serious problem as well. Studies have shown that people with disabilities

The Adverse Childhood Experiences (ACE) Study provides data linking adverse childhood experiences such as sexual abuse and witnessing domestic violence as factors contributing to psychiatric illness, substance abuse and other health problems (Felitti et al, 1998). However, the extent to which these and other issues make a person more vulnerable to interpersonal violence requires more study by feminist researchers.

It is important to emphasize that people who experience interpersonal violence neither “ask for” nor deserve violence or abuse – no matter what else is going on. The most important message you can give a person whose experience includes multiple abuse issues is, “This is NOT your fault.” This message is especially important if individuals

have a four to ten times higher risk of becoming crime victims than persons without disabilities (Wayne State University, 2002).

- **Poverty.** Studies show that over 50 percent of women receiving public assistance report having experienced physical abuse at some point in their adult lives, and most of these women also report a history of physical and/or sexual abuse in childhood (Lyons, 2000).

- **Homelessness.** One study found that 92 percent of homeless women had experienced severe physical or sexual abuse at some point in their lives. Of all homeless women and children, 60 percent had been abused by age 12, and 63 percent have been victims of intimate partner violence as adults. Among cities surveyed by the U.S. Conference of Mayors in 2003, 44 percent identified domestic violence as a primary cause of homelessness (National Network to End Domestic Violence, 2004).

- **Sex trafficking.** Although not all sexually abused children are recruited into commercial sex, the majority of individuals involved in the commercial sex industry have a history of sexual abuse as children, usually by several people (Farley, 2003). One study found that 66 percent of people involved in commercial sex were victims of child sexual abuse. Women sexually abused as children are four times more likely than women who haven't been abused to work in the commercial sex industry, while men sexually abused as children are eight times more likely to work in the commercial sex industry (ICASA, 2001).

- **Incarceration.** Incarcerated people have a history of trauma at much higher rates than the general population. The rate of physical or sexual abuse or violence experienced by incarcerated women, either within their families or by intimate partners, is quite high – estimates vary from 44 percent to 80 percent – compared to that reported by women in the general population – a 30 percent lifetime occurrence (O'Brien, 2002). In a study of inmates at a Midwestern state prison, 22 percent of male respondents said they had been forced to have sexual contact against their will at least once while incarcerated (ICASA, 2001).

were under the influence of alcohol or drugs, were experiencing psychiatric symptoms, or were coping with other co-occurring issues at the time an abuser took advantage of and hurt them.

“There are confusing mixed messages when the people we serve are not ‘perfect victims,’ and they fight back, and they also – in the grips of their addictions – commit crimes,” says Seattle behavioral health specialist Karen Foley. “And then, at the same time they’re dealing with sexist issues, they’re dealing with poverty. They are oppressed in society. It’s just so intertwined.”

Along with a non-judgmental, non-blaming message, it is also important to offer a message of hope. While we can acknowledge that co-occurring issues may make it harder for people to get safe, sober *or* whole, people experiencing multiple abuse issues must be reminded that they are in control of their own decisions. They have options and advocates to support their safety, autonomy and justice. We can listen, believe them, validate the choices they make, and help them feel connected.

Another layer of trauma: Societal abuse and oppression

An additional layer of trauma may further complicate the situation for people who are survivors of multi-abuse trauma. In addition to the stigma and barriers surrounding issues such as a substance use disorder, psychiatric illness, and various forms of trauma, they may be facing societal abuse.

Societal abuse refers to the disadvantages that a group experiences as a result of unjust social structures (Benbow, 2009). An example is discrimination and oppression based on misperceptions about race or ethnicity, age, socioeconomic status, disabilities, sexual orientation and immigration status. Manifestations may range from lack of accommodations to inadequate funding for social services, lack of access to health care, inadequate social policies to protect against abuses, and negative images and stereotypes in the media (Schwartz-Kenney et. al, 2001).

Marginalized groups are disproportionately affected by poverty, homelessness and incarceration – not because they commit more crimes or have greater rates of pathology, but because discrimination often keeps them from getting the same benefits enjoyed by members of the dominant culture (Davies, n.d.; Cawthorne, 2008; HUD, 2007).

Discrimination and other forms of societal abuse are traumatic to the people who are targeted and can, in themselves, result in post-traumatic stress. Some experts speak of *minority stress* (Green, 2007) and *postcolonization stress disorder* (Comas-Diaz, 2007), which result from struggling with discrimination and oppression, as well as the imposition of mainstream culture as dominant and superior. Psychological effects include depression, shame, rage and posttraumatic stress disorder.

Naomi Michalsen, Executive Director of Women In Safe Homes (WISH), in Ketchikan, AK, discusses the anger:

“A lot of my Native brothers and sisters are angry. They’ve realized a little bit about what happened. In order to begin healing, I believe we need to come to a point where we try to understand, or acknowledge, some of the things that happened and talk about all those things we know – and be believed. In a way, part of that has to come from learning about our culture again and the values” (Michelsen, 2007).

Internalized oppression occurs when people absorb society’s attitudes toward their particular group and direct those negative attitudes toward themselves (Green, 2007). One can think of internalized oppression as the internalized police officer that keeps

individuals in their socially prescribed place (Roy, 2007). Sometimes the internalized oppression can take a tragic turn, according to Shirley Moses, Shelter Manager at the Alaska Native Women’s Coalition in Fairbanks, AK:

“One thing that has come full-blown now, and that the state has recognized, is young men or young women committing suicide tied to sexual abuse, or tied to violence in the home. They are looking at the bigger picture, saying there’s underlying reasons that need to be addressed so we can help villages and our people get healthier – and we can address suicide as something tied to domestic violence, child maltreatment and the breakdown of the families” (Moses, 2010).

Trauma can also be passed from one generation to the next. Experts use the term *intergenerational grief* to refer to grief passed on from the generation experiencing the trauma to their children even though they may not be aware of or have direct experience of the actual traumatic event. *Historical trauma* refers to cumulative trauma that occurs in history to a specific group of people, causing emotional and mental wounding both during their lives and the generations that follow (AIFACS, n.d.). Shirley Moses relates:

“Historical trauma is never addressed. And there are layers. We’ve had women that are 70 and 75 years old report being traumatized, maybe for the first time, because we were doing DV 101, and talking about sexual abuse. And that historical trauma piece, they were reporting in our training for the first time that they had been sexually abused as children. So you go back to pre-contact or early contact, when we had traders or outside people coming into Alaska. There was that life change where you had clashes between the Native culture and the non-native cultures, and the disconnect. The leadership was different. A lot of places don’t have the traditional Native leaders. The elders are not utilized as experts as much. It’s changing, but there’s still a long way to go. And the reconnect of teaching our children and our youth and our young parents to honor their culture, to honor their ways, to honor their ancestors, I see that changing, but it’s so slow. And a lot of our young people don’t even recognize a way they can regain the old social norms. A lot of them have struggled with the cultural beliefs, and the leadership. I think that’s starting to shift, because we are talking about it more, the way that disconnect has hurt our villages. But I think that intergenerational grief, it’s loss of culture. Lots of our young people don’t speak the native language” (Moses, 2010).

Barriers to service for people seeking help

Very few programs provide comprehensive services for people impacted by multiple issues. Survivors of multi-abuse trauma are often invisible when in our programs, or are perceived as disruptive when co-occurring issues such as substance use or psychiatric symptoms become evident or unmanageable. Many times people with co-occurring or multiple abuse issues are missing from community programs altogether.

Victims of domestic violence and survivors of sexual assault who struggle with multi-abuse trauma often need our services the most. Yet, having multiple issues makes it

harder for a survivor to access appropriate services in a variety of ways:

- *Confusion over how to access services.* One study found that people with mental health concerns are often confused over how to access and use available services. The more severe the psychiatric disability, the greater the level of confusion (Rosenheck & Lam, 1997). This can be an issue for people who have other co-occurring issues as well.
- *Lack of self-advocacy skills.* Not knowing how to advocate for oneself can pose a significant problem for people coping with multiple issues (Obtinario, 2010). A survivor shares:

“I didn’t go to the doctor until several weeks after I was assaulted. And when I told them what had happened to me, they just sort of patted me on the head and said, ‘There, there.’ There weren’t any marks at that point. So it was like, ‘Let’s give her some Librium for a few days to calm her down. And give her some antidepressants.’ Five months later we found out that my neck had been broken. Because I did not advocate strongly for myself, and because I was docile and withdrawn, they weren’t very aggressive about checking out my health. That could have been very dangerous for me. So I think it’s very important for medical providers, when they learn that somebody has had domestic violence, to do a very thorough examination. Because I was incapable of being assertive for myself at that time, I didn’t get the medical care I really needed.”

- *Fragmented services.* For people who live in urban areas with many kinds of services, the system may be fragmented and they cannot receive everything they need from one provider (Akers et. al., 2007). An individual may need to go to one provider to access domestic violence services, another provider to obtain treatment for a substance use disorder, still another provider for mental health services, and several more providers to receive public assistance.
- *Hard-to-access or nonexistent services.* If someone lives in a rural or remote area, these same services may be extremely hard to access, or may not be available at all. Shirley Moses of the Alaska Native Women’s Coalition points out the challenges faced by women who live in remote communities:

“There aren’t the services out there, or it is cost prohibitive. Most airline fares are \$200-\$300 per person one way, and most of the women have two or three children at least. Even if you have money to fly them out, there might be a storm like we had last week where you had everything close down because it was raining for four days. If it freezes you have planes sliding off the runway. Then there are snowstorms. She could be from a village that is out of the region, and if she is in a domestic violence situation, her family might be 500 miles away in a different part of the state where you have to come to Fairbanks, go to Anchorage, go to Bethel, and then get to one of the hub villages” (Moses, 2010).

- *Lack of family-focused services.* Services for parents and children may be fragmented. Funding streams, and program eligibility requirements for mental health centers and other

services may limit participation to eligible adults or children, but not both. Services for adults and children may be provided in different locations. Programs or treatment settings may not allow adults to bring their children with them – e.g., emergency shelters or residential programs (Nicholson et al., 2001).

- *Conflicting expectations.* Each provider may have different rules, some of which conflict. For example, a substance abuse treatment program may require attendance at a group counseling session that extends until after the curfew at the domestic violence shelter where an individual is staying. A public assistance program may require applicants to be seeking employment, while some “half-way houses” may require the same individual to delay seeking employment until after completing other goals identified in treatment plans. Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle, offered the following example of how conflicting expectations can affect a person who must seek services from more than one agency:

“I had someone who was sitting at an inpatient treatment center, and her TANF money was sanctioned. When I took her to the local community service office to talk with her TANF worker, the TANF worker said they were available at a certain day, at a certain hour to discuss this and that’s it. So this individual is sitting in an inpatient treatment center where they are mandated, if they want to keep their children, to attend every treatment hour offered. They cannot miss a treatment hour. There are only certain hours they can take care of business. If she wants to keep her child, she must attend treatment and if she wants to stay in treatment she has to follow these rules. At the same time, in order to stay in treatment, she needs to pay for it, and her child is charged \$300 a month to be in treatment with her. If her money continues to be sanctioned, she doesn’t have the money to pay for treatment. So the inflexibility of the system in being able to work with her made it impossible for her to not continue getting sanctioned” (Foley, 2010).

A survivor of multi-abuse trauma shares her experience of not being taken seriously:

“I didn’t go to the doctor until several weeks after I was assaulted. When I told them what had happened to me, they just sort of patted me on the head ... Five months later we found out that my neck had been broken.”

- *Inability to afford services.* People may be unable to afford some mental health or substance abuse treatment services if they do not have insurance, or if they have insurance that doesn’t cover services adequately (a problem for an increasing number of middle-class people as well as people living in poverty). Even if services such as domestic violence advocacy, sexual assault counseling or mental health services are offered free of charge by advocates or other providers, some people may not be able to

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SAFETY ISSUES: MULTI-ABUSE TRAUMA

Co-occurring issues such as a substance use disorder, mental health concerns, disability, societal oppression or poverty can make it harder to get safe from interpersonal violence or abuse. At the same time, inability to get safe or heal from interpersonal violence makes it harder to address other issues.

Co-occurring issues make it harder for victims of interpersonal violence to get safe in a variety of ways:

- The co-occurrence of domestic violence and substance use (or misuse) is well documented and associated with increased lethality rates and greater severity of injuries for people impacted by these public health risks. Severity of injuries and lethality rates climb for individuals who experience both substance dependence and battering (Dutton, 1992). Acute and chronic effects of alcohol and other drug use may prevent a victim from accurately assessing the level of danger posed by a perpetrator (Bland, 2007). Alcohol and other drug use may be encouraged or forced by an abusive partner as a mechanism of control, and abstinence and recovery efforts may be sabotaged (IDHS, 2000). For example, a domestic violence/sexual assault victim receiving methadone on a daily basis could easily be stalked.
- Psychiatric symptoms can have an impact on safety (Bland, 2007). Accurate assessment of danger may be impacted by thought disorder symptoms. Traumatic brain injury or psychiatric symptoms can impair judgment and thought processes (including memory), making safety planning more difficult. There may be reluctance on the part of the individuals with psychiatric symptoms to seek assistance stemming from fear of being labeled, institutionalized or medicated.
- Both mental and physical problems, whether temporary or more long-term, can diminish some people's ability to work, participate in job training or education programs, or comply with government benefit requirements (Davies, n.d.). All of these factors can make it harder to escape violence.
- Some people with disabilities depend on caregivers – either a spouse, other family members, or paid assistants – for essential personal services. This can create a barrier to terminating an abusive situation because to do so would leave the victim without essential support services (Wayne State University, 2002).
- If someone has a developmental disability, cognitive and processing delays may interfere with the ability to understand what is happening in abusive situations. This problem is compounded by the fact that people with developmental disabilities are often not provided with general sex education, so they may not recognize what is happening to them in a sexually abusive situation (Charlton, et. al., 2003).

- Being a member of an oppressed group can pose safety issues. For example, some people of color may be reluctant to report violence because of their community's negative experiences with police, while fear of exposure – or being “outed” – may prevent lesbian, gay, bisexual or transgendered people from seeking help to end violence (IDHS, 2000).
- A person experiencing poverty may find it much more difficult to implement a safety plan. People must be able to financially support themselves and/or their children after leaving an abusive partner. Most programs that provide housing, temporary cash assistance, child care, and free legal representation have limited funding or offer only short-term help, and many have extensive waiting lists. As a result, some low-income individuals simply are without the income, government support, or access to services necessary to fully implement a safety plan (Davies, n.d.).
- Fear of legal sanctions can interfere with safety as well. People victimized by violence may be reluctant to contact police or seek other assistance for fear of prosecution, investigation by a child welfare agency, or deportation – especially if they disclose illegal immigration status, use illicit drugs or have engaged in illegal activities such as theft or commercial sex to support an addiction (IDHS, 2000).
- Trafficking victims and people being exploited by the sex industry generally lack access to money, “systems” or those who could help them to escape. Trafficked persons may also be from outside U.S. borders, which may leave them in fear of deportation (Song & Thompson, 2005).

Inability to get safe or heal from interpersonal violence also makes it harder to address co-occurring issues:

- For people in substance abuse treatment, failure to address current or past victimization can interfere with treatment effectiveness and can lead to relapse (SAMHSA, 1997). Someone in recovery for a longer period of time also may find the stress of securing safety leads to relapse.
- Abusers may try to prevent victims from keeping appointments for mental health counseling, obtaining public assistance, or seeking other services. Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at S.T.A.R. (Standing Together Against Rape) in Anchorage, AK, says:

“I think a lot of the people we see have partners that are keeping them intoxicated or encouraging them to over-medicate, not relaying our messages to the victims when we are calling them, not wanting to bring them into the office, or allowing them to come and then calling them five times on their cell phone as we are sitting together in a one-on-one session” (Patterson-Sexson, 2010).

afford babysitting, accessible transportation, or (for people with disabilities) medical equipment or a personal attendant (Leal-Covey, 2011). A fragmented system makes services harder to access, particularly for someone who lacks accessible transportation.

- *Cultural barriers.* People from marginalized groups often find it harder to access social services – especially if most of the staff represent the dominant culture, or services are based on the values and customs and beliefs of the dominant group (Duran, 2006). A social service system dominated by Western ways of approaching issues may feel intimidating. There may be language barriers, or customs that feel alien to the individual. Even the food served at a shelter or residential facility may be alien. Erin Patterson-Sexson at S.T.A.R. in Anchorage offers an example:

“In addition to a large Native Alaskan population, we have a lot of Hmong, Pacific Islanders, women from all parts of Asia, and most of the advocates here are Caucasian. Many victims are afraid of law enforcement, and see any kind of helping service as a betrayal of their family, a betrayal of their culture. So they don’t seek the services or they don’t continue with us beyond the crisis intervention phase.”

- *Lack of accessibility.* According to the National Coalition Against Domestic Violence and the National Coalition Against Sexual Assault, inaccessibility in shelters is a serious problem for people with disabilities. These programs generally operate on very thin budgets and covering the cost of accessibility modifications and services is a substantial challenge. One study found that only about a third of providers offered safety plan information modified for use by people with disabilities, or disability awareness training for program staff, and personal care attendant services were available in only 6 percent of abuse programs (Nosek et. al, 1997).

- *Housing discrimination.* Individuals and families across the country are being discriminated against, denied access to, and even evicted from public, subsidized, and private housing because of their status as victims of domestic violence or the abuse perpetrated against them. Landlords frequently turn away individuals who have protection orders or other indications of domestic violence (National Network to End Domestic Violence, 2004). This means a person seeking services may need emergency shelter for a longer period.

- *Restrictions on length of shelter stays.* The average stay at an emergency shelter is 60 days, while the average length of time it takes a homeless family to secure housing is six to ten months. Many domestic violence shelters are unable to house families longer than 30 days to allow space for individuals in immediate danger. There are not enough federal housing rent vouchers available to accommodate the number of people in need. Some people remain on a waiting list for years, while some lists are closed (National Network to End Domestic Violence, 2004).

Challenges for providers

Co-occurring issues create challenges for shelter staff and other service providers:

- *Behavioral challenges.* Some behavior may pose challenges for staff (IDHS, 2000). For example, a person who suffers from depression may have difficulty achieving goals or performing tasks in a timely manner. A person with substance use disorder may repeatedly violate a shelter’s curfew or come back to the shelter intoxicated. A person with psychiatric symptoms may behave in ways perceived as disruptive to staff and other residents. Behaviors stemming from trauma, self-harming actions such as cutting, or suicidal threats may make group living challenging. Psychiatric issues, developmental disabilities or language barriers may make it harder to understand or follow certain rules.

- *Lack of cross-training.* Advocates and other providers often lack training on issues other than the one for which their own agency provides services (Akers et al., 2007). When this is the case, they will have valid ethical concerns about working beyond their competence level (SAMHSA, 1997).

- *The complexity of the individual’s problems.* Services for people with multiple issues need to be intensive and personalized, and providers must focus on both short-term and long-term needs. This is not to say that specialized, single-focus agencies such as domestic violence shelters, substance abuse treatment programs or mental health centers don’t work. They do, for a lot of people. But a survivor of multi-abuse trauma usually needs more than what any one agency can provide, no matter how competent we are.

- *Funding barriers.* Social service agencies depend on continuous, reliable funding to remain in existence. Whether the money comes from government sources or the private sector, many funders want to see “numbers” and clear-cut “evidence-based” results. This system tends to benefit agencies who can help large numbers of people resolve their issues, once and for all, in a short period of time. Helping a survivor of complex trauma resolve multiple issues may require months or even years of intensive services (Courtois, Ford & Cloitre, 2009), and results may be difficult to measure short-term. A provider’s particular service may be only the first step for this person.

- *Personnel shortages.* Limited budgets, geography and weather often mean staff and resources are stretched to the limit. Shirley Moses of the Alaska Native Women’s Coalition discusses the situation in rural and remote areas of Alaska, where a quick response can mean life or death. Bad weather, long distances and a limited number of available law enforcement personnel might slow a response to sexual assault or domestic violence in a remote or rural community for hours or days at a time:

“We have four troopers for, I think, 20 or 30 villages here in the interior. Four full-time troopers, and they have to sleep sometime. And they have limited access to

A survivor of multi-abuse trauma shares:

“As someone who has survived domestic violence, there’s an antenna on my head that can detect who is sincere and who isn’t. ... I tested many, many people to see if they were going to be loyal and confidential.”

airplanes or even commercial flights to fly in, especially in bad weather. Lack of resources – money is always a problem. It costs money to pay for law enforcement and the state has a limited budget and a lot of territory to cover” (Moses, 2010).

- *The desire for success stories.* Both funding organizations and the public tend to want success stories, in which the success is evident in a form that is measurable. This can lead to the temptation for service providers to engage in “cherry-picking.” Because of the desire to show funders that one’s program is successful, a provider may either consciously or subconsciously pick participants deemed to have the best chance of succeeding, while screening out those who might “fail” or those who would take too long to succeed. This can work against survivors of multi-abuse trauma who are dealing with multiple issues that take longer to resolve.
- *Manipulation by abusers.* Naive, inexperienced or inadequately trained staff may fail to fully understand tactics batterers use or underestimate their willingness to go to whatever lengths are necessary to maintain control of those they perceive as belonging to them. This serious mistake can leave providers vulnerable to manipulation by batterers and subject to collusion. Failure to identify risk undermines treatment efficacy and victim safety. It may also lead to increased liability.
- *Barriers to cooperation between providers.* Cooperation between providers from a variety of disciplines is needed in order to address the multiple issues involved in multi-abuse trauma. Developing linkages or collaborating across these sectors is fraught with problems, and many barriers to cooperation exist. These include differing priorities, funding restrictions, lack of trust between providers with differing philosophies, and lack of cross-training in issues other than the issue addressed by a particular agency.

Karen Foley is the founder of Triple Play Connections, a Seattle-based non-profit organization comprised of mental health, domestic violence, sexual assault and chemical dependency providers working together to cross-train and network in local neighborhoods throughout Washington State. She says:

“I think the biggest barrier [to cooperation between providers] is a lack of understanding of the other issues. Each of us has our own priorities as to what is the most important thing to work on and how to go about that. And we’re very strong in our knowledge base. But when you have intersecting issues, you can do more damage by believing your way is the only way, and by not talking to one another as providers” (Foley, 2010).

Consequences when co-occurring issues are not addressed

Advocates and other providers agree it is hard to meet higher-level needs such as emotional healing when basic needs such as food and housing are not met. Erin Patterson-Sexson at S.T.A.R. in Anchorage says:

“It’s like Maslow’s hierarchy of needs. You can’t deal with those intellectual and emotional needs until the basic needs are met. We are not getting anywhere if we are trying to address emotional needs when her rent is overdue and her heat has been turned off” (Patterson-Sexson, 2010).

When a multi-abuse trauma survivor’s issues are not adequately addressed, serious consequences may follow:

- Physical and medical problems can develop. “I’m a firm believer that when you’re in so much hurt and so much pain, you cannot go beyond a certain volume,” says Daisy Barrera, an advocate from Bethel, AK. “Your body’s going to break down” (Barrera, 2009).
- Ability to maintain employment, housing, health insurance or child custody may be threatened by current or past substance use disorders or mental health problems (Akers et. al., 2007). Societal attitudes tend to view substance use disorders and psychiatric symptoms as moral failings rather than as health problems. This can lead to isolation and shame, which may be compounded when domestic violence and/or sexual assault co-occur with these other issues.
- People with multiple issues may believe they have no other choice but to return to an abusive situation again and again, because they have nowhere else to go where they feel welcome or safe.
- Individuals may bounce in and out of the system, moving from one social service agency to another, resulting in a revolving door syndrome in which underlying problems and issues are never adequately addressed (Akers et. al., 2007).
- Survivors may develop coping mechanisms such as substance abuse or eating disorders to deal with continuing trauma, or to self-medicate post-traumatic stress disorder stemming from interpersonal violence or abuse (Bland, 2007).
- Inability to access appropriate services makes it more likely that trauma of all kinds will continue, resulting in even more trauma. “The traumas just keep compounding and compounding,” says Gene Brodland, a licensed clinical social worker at the Southern Illinois University School of Medicine (Brodland, 2010).

A survivor of multi-abuse trauma shares:

“I thought simply stepping back and not saying anything would help me. It didn’t. My body shut down to the point where I almost died, because I kept everything to myself. It turned medical, with pneumonia, which resulted in asthma, because I held that garbage. I carried that around in me without ever revealing it to somebody.”

- Ultimately, an individual may end up on the streets, homeless, or even incarcerated. A survivor shares how the cumulative effect of domestic violence on top of her history of trauma affected her:

“How did it affect me? In every way possible. It interfered with my sobriety. I ended up relapsing after many years of being clean and sober. I ended up losing my career. I lost the place where I lived. I became homeless. I was physically injured with permanent effects. My ability to form relationships with people suffered – my gosh, I already had trust issues. I still do, and I’m 55 years old.”

Meanwhile, abusers are not held accountable for their actions and benefit from lack of services for victims with multiple abuse issues. Abusers also benefit from the stigma and discrimination survivors with multiple abuse issues face. This stigma and discrimination is often fostered by abusers who use substances to induce debility and better control their partners (Hampton, 2005). Abusers may encourage, trick or force a targeted individual to use substances to facilitate rape, to undermine their victim’s credibility, their access to their children and their access to support of any kind.

Yet another layer: Trauma from the system

Finally, people with multiple issues may experience trauma from the very social service system that was designed to help them. The inability to access appropriate services creates its own stress. The system itself thus adds to, rather than alleviates, their problems:

- When social service fragmentation leads to people getting passed around to numerous providers, these individuals may be left with the feeling no one cares about them or wants to deal with their issues.
- Each provider may have their own theory about what causes human problems. If people who seek help are pressured to adopt these conflicting theories, they may become confused and angry.
- As people with multiple issues revolve around the system, they may acquire multiple labels. They then become defined by their labels rather than viewed as human beings, and are thus dehumanized by providers in the system as well as by their abuser.
- The experience of being labeled, dehumanized, and passed around the system re-traumatizes people with multiple issues, making it even more difficult for them to address their issues.
- For many survivors of trauma who have disabilities or psychiatric issues, systems of care perpetuate traumatic experiences through invasive, coercive or forced treatment that causes or exacerbates feelings of threat, a lack of safety, violation, shame and powerlessness (NCTIC, n.d.).

- Intimate partner violence, substance abuse or dependence, and mental illness all may result in a person becoming homeless (NCH, 2006). Psychiatric symptoms and homelessness have become criminalized, and jails and prisons have become a dumping ground for warehousing people with mental health issues and people who are homeless (Treatment Advocacy Center, 2007).
- The tools a person uses to cope with trauma – such as substance abuse, commercial sex or running away from home (if under 18 years old) – are often pathologized or criminalized (Gilfus, 2002). An example of this would be an adolescent girl who runs away from home to escape incest and is forced into commercial sex or is incarcerated in a juvenile detention facility.
- The physical and psychological violence of commercial sex or sex trafficking, the constant verbal humiliation, the social indignity and contempt, can result in personality changes that have been described as complex posttraumatic stress disorder, particularly if the individual was forced into the sex trade (Herman 1997).
- People who become homeless find that homelessness itself is a traumatic experience. Individuals and families who are homeless are under constant stress, often unsure of where they will sleep tonight or where they will get their next meal (Barrow et. al., 2009).
- If people with multiple issues end up homeless or incarcerated, they may then suffer posttraumatic stress disorder from the homeless or incarceration experience (Wong, 2007). A person who has been incarcerated – especially if incarcerated more than once – may suffer from *post-incarceration syndrome*, a form of post-traumatic stress disorder stemming from the incarceration experience itself (Gorski, 2001).
- People experiencing multiple forms of abuse may actively hide what has happened to them, as well as their methods of coping. Thus, their experiences of multiple forms of abuse become invisible.

Policies and practices may deny or limit services for individuals who have been exploited by the sex industry or incarcerated, or who experience chronic homelessness. Shelter and other services may also be denied to people who currently experience suicidal ideation, use substances or have some other issue perceived as problematic.

This response silences those who seek services, drives these issues underground and rewards those who can cover up best. The secrecy and invisibility lead to more juggling, more trauma, more shame and greater risk for future harm as survivors increasingly fear revealing who they really are and remain invisible, silent and afraid to ask for what they really need beyond what is most pressing.

As one survivor shared, “When someone has a gun to your head, you are not going to tell the advocate on duty you just shot up. You’ll say anything to get in the door.” Survivors may want to please advocates rather than disappoint them. They may fear being judged, reported to authorities, kicked out, or labeled.

Additionally, some advocates may be afraid to ask survivors about indicators of substance use or other concerns, due to fear. This may be fear the advocate won't know what to do, fear of how the individual seeking services will react, or fear the advocate will have to ask the individual to leave.

The resultant aura of invisibility maintains an uneasy status quo that can be shattered at any moment. Should a problem erupt, its exposure has the capacity to overwhelm a survivor's ability to function – let alone experience safety, autonomy and justice. A punitive response could also lead to increased trauma, isolation and shame.

Behavioral health specialist Karen Foley of Triple Play Connections believes social service providers must cooperate and work closely together in order to avoid further traumatizing victims of violence who have multiple issues:

“Probably the biggest example that demonstrates this is when providers say, ‘We’re not equipped to deal with that issue.’ While we certainly don’t want providers to practice outside their area of expertise, we absolutely need to deal with it, and know our local providers and refer to the experts, rather than denying access to services” (Foley, 2010).

Providers across disciplines have begun to agree that we all must broaden our focus to at least consider what other issues people may be facing when they come to us for services. Gene Brodland, of the Southern Illinois University School of Medicine, says:

“I think unless you have a very broad definition of who you are and what kinds of things you address, you become extremely limited in terms of what you can do to work with someone. When you only throw a drug at them, or you only throw alcohol treatment at them, or you only throw some other kind of service at them, and you don’t consider the other issues, you’re really letting them down. You’re going to miss the very essence of caring for human beings” (Brodland, 2010).

HOW SHOULD ADVOCATES RESPOND?

If helplessness and isolation are the core experiences of trauma, empowerment and reconnection are the core experiences of safety and healing (Herman, 1997). We can support survivors seeking safety, sobriety, wellness, autonomy and justice by reducing program service barriers and ending isolation for people impacted by multiple abuse issues. Policies and procedures to ensure culturally competent, appropriate, non-punitive and non-judgmental accessible services are key.

Creating a welcoming environment

Fleeing violence disconnects individuals and families from familiar stress management strategies and creates new stresses, whether or not there are co-occurring issues such as psychiatric symptoms, disabilities or cultural issues. Details ranging from staff behavior and attitudes to the way physical space is designed can send a subtle message regarding how agencies feel about the people they serve, and can either reduce or add to stress (Prescott et. al., 2008).

“There are small actions that will plant the seed that someone truly cares,” says Daisy Barrera, an advocate from Bethel, AK. “You’re measured at all times.” Here are some ways to create a safe and welcoming environment:

- Make sure there is good security lighting outside the building.
- Have comfortable sofas and chairs, a selection of magazines, toys or coloring books for children, and coffee, tea or soft drinks on hand in the waiting area.
- Add “home-like” touches. Some inexpensive ways to make physical space more inviting include plants, fish tanks, throw pillows on couches and chairs, area rugs, and artwork on the walls (Prescott et. al, 2008). Agencies that publish a newsletter could put these items on a donations wish list.
- Pay attention to accessibility issues – enough space for people using wheelchairs or other assistive technology to move around, and items where people with disabilities can reach them (Leal-Covey, 2011).
- Keep paperwork to a minimum during initial intake sessions (Warshaw, 2010).
Prioritize: What paperwork absolutely must be done right away, and what can wait until later sessions when people seeking services have had a chance to get comfortable with staff and with their surroundings?
- Ensure complete confidentiality for counseling sessions and other situations in which

people seeking help will be sharing sensitive information. A private office space that allows staff to shut the door is ideal.

- In a residential setting, provide private retreat spaces other than bedrooms, such as quiet rooms or meditation gardens.
- Tell every person who enters your program, “If something here makes you feel unsafe or uncomfortable, let me/us know. We will try to make things more comfortable and safer” (Pease, 2010).
- Always convey respect, in both words and actions. Advocate Daisy Barrera says:

“It’s critical for professionals to be considerate, to be respectful, to be understanding, to be supportive. Supportive can mean just being there by the person’s side. You definitely don’t always have to say anything or speak. We can spend a lot of money trying to do anything and everything to help those who are hurting. That money means nothing to an individual who is hurting until we as professionals take the time to respect, accept, and grow those big moose ears or elephant ears when a person is speaking to you” (Barrera, 2009).

Trust isn’t always easy

People who have been traumatized by multiple issues may have trouble trusting others, even those who appear to have good intentions. Survivors may not trust advocates, counselors, therapists or other social service providers for a variety of reasons:

- *Negative past experiences with social service agencies or providers.* People with multiple co-occurring issues may have been passed from one agency to another for years without getting their needs met, or they may have encountered providers who treated them in ways that felt confusing or disrespectful. A survivor shares:

“For someone such as myself, who has survived severe domestic violence, there’s an antenna on my head that can detect who is sincere and who isn’t. I feel people quicker, faster. I tested many, many people to see if they were going to be loyal and confidential.”

Another survivor shares: “I called a crisis line and talked to somebody, and there was no room in the shelter. I made that one call. That was it.”

- *Fear of authority figures.* People who are survivors of interpersonal trauma often have a history of encounters with authority figures who abused power, discounted them, blamed them for their problems or used what they said against them later.
- *Fear of legal sanctions.* Survivors may fear prosecution if they disclose illicit drug use or other illegal behavior such as theft or commercial sex. An individual who has been

incarcerated may fear going back to jail or prison. A person with immigrant status who is in the country illegally may fear being deported.

- *Fear of being judged.* People may have heard repeatedly that their problems are caused by their own behavior, lack of personal responsibility, inappropriate decisions or bad character traits. A survivor shares:

“After my last assault, I went to a mental health counselor. I finally got the courage to go. It took a lot for me to ask for help. After the second time visiting him, he asked me, ‘What did you do to piss him off?’ And that was it. I never went back. And it was a very long time before I talked to another counselor again.”

- *Fear of being discounted.* People who have been victimized by interpersonal violence often have a history of not being believed when they are telling the truth, especially if they have co-occurring issues such as a substance use disorder, mental illness or disabilities.

- *Fear of encountering stereotypes on the part of the provider.* Some survivors have encountered people who avoided or excluded them because of race, culture, disabilities, socioeconomic background, experience of violence, substance use history or mental health status. Previous providers may have displayed distrust because of stereotypes or unconscious bias, and created rules and restrictions based on this lack of trust.

- *Fear of losing children.* Some people fear that disclosure of parental substance abuse, mental health concerns, domestic violence or illegal activities will trigger an investigation by a child welfare agency. Survivors who have a substance use disorder, psychiatric symptoms, or other disabilities, may fear being judged incompetent to provide adequate parenting. Fear of losing children is compounded when perpetrators threaten to report their non-offending partners to child protective services as an abusive tactic designed to maintain power and control over them. Survivors may fear false and unjust allegations made by an abuser or an abuser’s family will lead to an investigation resulting in loss of child custody. Shirley Moses, Shelter Manager at the Alaska Native Women’s Coalition in Fairbanks, AK, says:

“A lot of women, if they leave the village, are looking over their shoulder wondering if the Office of Children’s Services (OCS) is going to come after them because they’ve put their kids in harm’s way. And we keep on telling them, they’ve taken the first step to keep their children safe, and they shouldn’t look on that as being a negative. They’ve had such bad incidents with their perpetrators or their perpetrator’s family calling and unjustly saying that they’ve neglected their children” (Moses, 2010).

- *Fear of being denied services.* Some survivors may fear being barred from a shelter or residential facility, denied public assistance or disqualified from other benefits if they disclose issues such as domestic violence, substance abuse, psychiatric issues, involvement in commercial sex or past incarceration. People who receive public assistance may fear losing benefits if they disclose that they are living with a partner.

- *Fear of losing autonomous decision-making power.* Providers who think they know an individual's needs better than she does may try to impose their own solutions and values. People who must abide by curfews or request passes (get permission) to see friends or relatives may feel as if they are being treated like children.
- *Fear of reprisals.* People victimized by interpersonal violence may fear retaliation from the perpetrator if they report sexual assault to the police, seek an order of protection against a violent partner, or report any kind of abusive behavior directed toward them in an institutional setting.
- *Fear of being scapegoated.* Some individuals may fear being accused of things they didn't do. For example, someone who discloses a history of substance abuse or incarceration may be the prime suspect if something turns up missing from a shelter or residential facility.

In turn, providers may have difficulty trusting the people who seek their services because of stereotypes and conscious or unconscious bias, and may create rules and restrictions based on this lack of trust. Ultimately, mistrust stemming from stereotypes, wrong perceptions and negative assumptions may serve as an excuse for advocates and providers to create oppressive, disempowering rules and restrictions rooted in ignorance, bias and fear (Leal-Covey, 2011). This misuse of power is counter to the mission of the victims' advocacy movement and has the potential to confirm seeds of doubt planted by an abuser who may very well have said, "After a week in the shelter, you'll be back."

Gaining trust

Despite valid reasons for not trusting others, people with a history of trauma need someone they trust enough to honestly tell as much of their story as they choose to share when they are ready, if safety and recovery and healing are to occur (Herman, 1997). Here are some ways to demonstrate your trustworthiness and begin the process of gaining trust:

- Be willing to earn trust. Try not to be hurt or offended if a traumatized person who has been battered or sexually assaulted is angry or doesn't trust you right away. Allow people you serve to take as much time as they need to begin to trust you. Understand that this lack of trust has more to do with their life experience and your role than it does about you personally. A survivor shares that it was hard for her to accept help at first:

"I think my wall was up, and I don't think there was anybody who could have gotten in there. I wasn't ready for anybody to help me."

- Recognize all people need to earn trust and advocates, counselors and authority figures are no exception. Trust isn't automatic just because someone wants to help or is in a position of authority. Bethel advocate Daisy Barrera says:

“I try to help individuals understand that when we are building trust, and trust is established, it’s more precious than gold. And it’s the bottom line” (Barrera, 2009).

- Encourage individuals to participate in developing safety, service and/or treatment plans. This can help give them a sense of control.
- Explain what you are doing, and why, up front. No surprises. If people we serve suspect that information is being withheld from them or that they are being manipulated in any way, trust often evaporates.
- Understand that confidentiality is paramount in gaining trust, as well as an ethical imperative. Daisy Barrera points out:

A survivor of multi-abuse trauma shares:

“I made sure that all the people I had to trust had a position where they had to keep their mouth shut. So if I told them something, they had to keep it in confidence. I had major trust issues.”

“Confidentiality is so extremely important. You have to remember, when a person has been abused or has gone through abuse, the first thing they learn is ... they can’t reveal, they can’t say, they can’t speak. You go through many tests.”

- Explain the limits of your confidentiality at the beginning of the intake process, before anyone begins talking. This may impact which issues an individual feels safe sharing with you. A survivor shares:

“I made sure that all the people I had to trust had a position where they had to keep their mouth shut. So if I told them something, they had to keep it in confidence. I had major trust issues.”

- Walk the talk. If we have a different set of standards for ourselves than we have for the people we serve, we convey the message we feel superior to them.
- Believe people who tell you about traumatic incidents. Do this, even if someone seems confused or out of touch with reality, or says something you perceive as inaccurate. Try asking yourself, “What might be happening to make this seem true for this individual?” Consider how certain behaviors and beliefs make sense or could be a reasonable response to multi-abuse trauma. Don’t ask, “Why are they acting this way?” Ask, “What happened to them to trigger this response? How can I help them find safer ways of coping that cause less grief?”
- Be willing to acknowledge when you don’t have all the answers, and be willing to help the people you serve get the information they need. Paula Lee, Shelter Coordinator at South Peninsula Haven House in Homer, AK, says:

“I’m not God, and I don’t know the right path for somebody else. I know if a person asks for something, I’m going to go get it. If she keeps asking questions, keeps wanting info, then I keep going and getting it, and that’s awesome! But if she gets what she needs after the first question and answer, that may be all that she needs or wants” (Lee, 2010).

Discussing co-occurring issues

Co-occurring issues may be easily missed if we don’t ask about these concerns in a non-threatening manner. Individuals may find it easier to talk about stress in their relationships or their partner’s substance use or mental health *before* talking about domestic violence, sexual assault, their own substance use, mental health or other personal issues. When discussing any of these issues:

- Children should not be present during discussions about abuse issues.
- Conversations must be respectful, private and confidential. Make the individual as comfortable as possible and assure confidentiality of records when applicable. Confidentiality is extremely important. People experiencing domestic violence or suffering from substance abuse issues may have been told they will be harmed if they reveal what is happening.
- Understand that individuals may have a variety of reasons for not leaving their abusers. Shirley Moses of the Alaska Native Women’s Coalition offers several common reasons:

“They may have a mom they are leaving, and they provide care or support to her. Or they have a job they can’t afford to leave. Or their partner, even though he is abusive, is the one – because of a lack of jobs – who hunts or fishes. Or they don’t have money to pay the rent or deposits to move in. They are pulling their kids out of school, and moving from a school that has 12 or 20 children to a school that might have 500 or 600 children. Or they are experiencing culture shock” (Moses, 2010).
- Validate the individual’s resourcefulness. Say: “I’m so glad you found a way to survive.” “You deserve a lot of credit for finding the strength to talk about this.” “You are here today and you are doing quite a bit right.” Credit each individual for finding a way to cope and offer options to make coping and surviving safer.
- At the same time, discuss risks in a respectful manner: “Drinking/drugging/cutting, etc. can kill pain for a while but there are safer ways of coping that can cause you less grief.” “Addressing these concerns can help you and improve your children’s safety and well-being, too.” Express concern about the risks of various issues for both the individual and any children. Provide objective information about possible legal and health consequences stemming from abuse concerns. A survivor shares:

“The advocate showed me this continuum of harm chart. The physical, it starts with

WHAT DOES SAFETY MEAN?

To survivors of domestic violence or sexual assault, safety means freedom from violence or abuse. While the primacy of safety should be emphasized for everyone, advocates will want to keep in mind that safety may mean additional things for people facing issues besides violence (Trujillo, 2009). Here are some examples of what people may need, in addition to freedom from violence, in order to feel safe:

For a person in recovery from substance abuse or addiction: Having a network of people who support recovery and sobriety. Being in an environment free of constant triggers or pressure to drink alcohol or use illicit drugs.

For a person with mental health concerns: Being able to talk about one's feelings and issues, or one's own view of reality, without fear of being discounted or acquiring yet another label. If on medication, having a reliable source of affordable refills, so one doesn't have to worry about running out.

For a person with disabilities: Full accessibility to any needed services. Freedom from bullying or exploitation. Being taken seriously rather than discounted. Being seen as a full-fledged human being capable of making one's own decisions.

For a person who has experienced societal abuse or oppression: Being in an environment where diversity is respected. Freedom from being bullied, discounted or discriminated against because of misconceptions about one's race, sexual orientation or other difference. Freedom to talk about one's feelings, issues or view of reality without being stereotyped.

For a person facing intergenerational grief/historical trauma: Having one's own customs, values and beliefs respected and honored. Freedom to practice one's own customs or hold one's own values and beliefs without pressure to conform to the dominant culture.

For a person living in poverty: Having a reliable source of income from employment, subsistence or public assistance. Ability to access enough resources to meet basic needs.

For a person who is homeless: A place to keep one's belongings without fear of them getting stolen. A place to sleep without fear of arrest or of being harassed. Privacy for such things as taking a shower or changing clothes.

For a person being exploited by the commercial sex industry: Being able to talk about what's going on in one's life without fear of arrest or stigma. Being able to choose where one works, or with whom to have a sexual relationship. Freedom from exploitation.

For a person who is or has been incarcerated: Freedom to come and go from one's place of residence without constant monitoring. The ability to discuss problems or challenges without fear of "getting violated" (an interesting turn of phrase that means getting sent back to jail or prison for violating probation or parole).

this. The verbal, it starts with this. The emotional and the sexual starts with this, and this is what happens at the end. Death. I remember the “death” word. I had never thought of that. There was no way I thought it would ever get worse. I couldn’t even see past that day. I was just surviving. When I looked at that, and thought about my children, it eventually sank in.”

- Ask open-ended questions: “What have you done to keep safe/sober/well up until now?” “What have you been able to do to care for yourself and the welfare of your children?” “What has worked well for you and the children and what has given you problems?” “Many people tell me they have tried_____. How often has this worked for you?”
- Validate concerns and use supportive statements: “I’m sorry this happened. It’s not your fault.” “Right now you may be feeling stress but there may be some safer coping tools you might like to consider.” “Give yourself credit. You’ve been doing your best in these circumstances.” Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at S.T.A.R. in Anchorage, AK, says:

“Some women have been programmed from the beginning of their lives that they are not worth anything. What they are worth is a good lay, cleaning up after somebody or making babies. If you’ve been told one million times in your life that you are nothing, and that you are not worthy of love and affection, it’s going to take advocates two million times to reinforce that you have value” (Patterson-Sexson, 2010).

Empowering survivors

Understanding multi-abuse trauma and its impact on safety, autonomy and justice is critical to empowering people with multiple co-occurring issues. Advocates and their community partners should have training and skills to recognize signs of co-occurring issues such as intimate partner violence, sexual abuse, substance use problems, previous trauma, disabilities, and mental health concerns (for example, anxiety, depression, suicidal ideation, thought disorders, etc.).

Here are some additional ways to ensure adequate service capacity and empower people with co-occurring issues:

- Develop policies and procedures to ensure program accessibility and non-judgmental, non-punitive service provision for people impacted by multiple abuse issues.
- Make it clear to the person (and to other providers) that nobody deserves violence or abuse, no matter what else is going on. Acknowledge the harm that has been done and say, “This is not your fault. Your children’s safety is important and so is your safety.” A survivor shares feeling confused about her reality:

“Was I this spoiled kid who felt victimized by my parents, or did this stuff really happen? We always had smiles on our faces so it must not have been real.”

- Validate the frustration that can occur when accessing needed services is difficult.
- “Normalize” responses to traumatic situations, rather than pathologizing the individual, and find a way to discuss co-occurring issues that is comfortable for both of you. A survivor shares:

“Once I got through the frozen stuff, I got mad. I was mad at the world. When I got angry, they didn’t say, ‘Oh, sh-h-h-h-h, don’t be angry.’ They gave me room, framing it as, ‘Well, it’s normal to be angry when bad things happen to you. To feel hurt and to be angry about that is normal.’ I didn’t have to be ‘the good victim.’ I was an alcoholic. I was mad as hell. I was not what you’d call the nice, quiet, docile victim when I showed up for services. And I was still accepted.”

- Avoid overwhelming an individual with too many referrals. Gene Brodland, a licensed clinical social worker with the Southern Illinois University School of Medicine, says:

“When you get 12 different providers for one person, they get overwhelmed. If they’re not ready to see the mental health provider, or they’re not ready to deal with their childhood sexual abuse, referral isn’t going to make a difference” (Brodland, 2010).

- Be flexible – allow people who seek our services to tell us what they need and when they need it, rather than taking a cookie-cutter approach. The relationship between the provider and the person seeking services should be more like a dance – with the provider following the individual’s lead. Gene Brodland says:

“This readiness factor is so critical. I have never changed anybody in my life. But I’ve seen people who are ready to change make some unbelievable changes. The question to ask is, ‘What is your priority right now? What do you think would help you the most?’ Getting a job may be down a ways on her priority list. Getting food may be her top priority” (Brodland, 2010).

- If you have had experiences similar to those of the person you’re serving, avoid projecting your own experience onto the other person. (“This is what worked for me, so you must do it too.”) Bethel advocate Daisy Barrera says:

“It’s critical, it’s a must, not to project our own experience onto another person, because each person experiences something individually. So I’ve practiced not to say to a person, ‘Oh, I went through that. I understand.’ I can’t say that, because it develops a shutdown. When someone comes to me and says, ‘I understand,’ in my mind I’m thinking, ‘You don’t.’” (Barrera, 2009)

- Provide intensive service coordination should an individual request it. Ensure that people impacted by both interpersonal violence and co-occurring issues know about

available resources. Explore options such as shelter, counseling, gender specific treatment, support groups addressing multiple problems, safety planning and linkage to other providers. Also discuss financial options, insurance and services for children.

- Change your attitude if you think leaving is the only answer. A victim of violence may have religious, economic, family or other reasons for remaining in the relationship and it is not our role to tell this person what to do. Likewise, harm reduction methods or choosing not to use medications may be controversial but also are options people with substance abuse or mental health issues may choose to explore. Karen Foley, advocate, behavioral health specialist and founder of Triple Play Connections, says:

“I think the biggest thing that providers need to keep in mind is, what does this person want as a goal? We are not the experts on what people want. We need to ask them what they want and how we can help, rather than tell them, ‘this is what you need’” (Foley, 2010).

- Affirm autonomy and the right to control decision-making. Affirm the individual’s choices and explain the benefits of safety planning, stopping or reducing the use of alcohol or other mood-altering drugs and seeking wellness. Advocates and other providers should offer respect, not rescue; options, not orders, and safe advocacy or treatment rather than re-victimization. Advocate Daisy Barrera says:

“No matter how many fancy words you may use, or come up with, a person will never take the first step on a healing journey until they’re good and ready to open that door themselves. The door will remain shut. It’s an individual decision. I help her to open her door” (Barrera, 2009).

- Approach teaching and learning as a two-way street. Fully understand that we can learn as much from the people we help as we teach.
- Try not to judge a person’s response as appropriate or inappropriate. Some behaviors may begin to make more sense when seen as responses to trauma – for example, some people who have been traumatized may use humor as a coping mechanism, while others may have a “flat affect” – that is, little reaction at all (Trujillo, 2009). A survivor shares:

“I would be talking to you about the rape as if it happened to someone else. I would not be outraged about what had happened. And I would have thought it was my fault. I would not have made eye contact with you. It would have been a struggle for you to get information from me.”

Using community support groups

Community support groups such as Alcoholics Anonymous or Women for Sobriety can serve as a valuable supplement to advocacy or counseling. Much of the power in these groups comes from being with other people who share similar experiences. Members of

the group share their success stories as well as what they're doing to resolve problems. A survivor shares:

“I had my A.A. family. There were a few old timers, and I would ask questions, and they would answer.”

Support groups can go a long way toward ending the isolation faced by people coping with both interpersonal violence and other issues. A survivor shares:

“Much of my family, even though they wanted to be a support, did not know how. So, for my own emotional safety, I kind of had to distance myself from them. I think I found some of the most valuable pieces of help from people that I knew who were in recovery, that had been around for a long, long time in recovery, and were gentle, forgiving, open spirits. That kind of held me up when I couldn't hold myself up. I'd have to say the most helpful of all were my close-knit friends in recovery, and my chemical dependency/domestic violence support group. They were the most helpful.”

A survivor of multi-abuse trauma talks about the importance of having supportive people in her life:

“The different women that I chose to hold my hand, I called them my Angels. ... I couldn't have done it without all the people that I had in my corner to help me. I wasn't alone anymore. It was amazing.”

Because recovery and healing from addiction or trauma can be a lengthy process, support groups can also be a valuable source of long-range ongoing encouragement. A survivor shares:

“The different places, and the different women that I chose to hold my hand, I called them my Angels. I went to AA, and then I accessed the group here at the shelter that I started going to. And then I got strong enough to see that I needed to go to rehab. I had to go to rehab for six weeks, and it was the best thing I could have done. Everyone came and saw me at rehab. So that was pretty cool. I'm a good people reader. You know how you can read people? They really cared. I had someone in my corner. I couldn't have done it without all the people that I had in my corner to help me. I wasn't alone anymore. It was amazing.”

Finally, most community support groups are free of charge, which makes them accessible to people regardless of income.

However, there are some important caveats involved when making a referral to support groups in the community:

WHAT HELPED US FEEL EMPOWERED?

Several survivors shared stories with us about advocates and other service providers who helped them feel empowered.

For one survivor, it was a willingness to explain things in understandable terms: “She was very gracious. And very clear – not giving demands, but laying out very clearly, ‘These are the steps. First you need to do this. And then you need to do this. You need to get a letter from your doctor. When you get the letter from your doctor, this is what you need to do. And then after you do that, this is what you need to do. And then I want you to call me. Let me know what happened.’ So she was not telling me what to do, but was explaining the process in very simple terms. She was not saying, ‘These are the rules and you will live by the rules.’ She was open, clear, considerate, and communicated that she cared.”

Another survivor shares how a service provider recognized that small, scared child inside: “She told me how old my inner child was. I think that was what opened up the door for me. She had all these answers that I didn’t have. Then I started feeling like a two-year-old sponge. I was soaking up everything that she said.”

Still another survivor valued the validation of her parenting skills: “There was a little magnet from Head Start that said, ‘I am my child’s teacher.’ This magnet is still in my home. With my young children during this time, we had this very patient woman from Head Start who came and did home visits with us. She’s still part of our family today. She was just wonderful. She was a big part of my realizing that I have to teach my children.”

And, of course, a willingness to listen mattered immensely: “They were willing to listen to me and it was through those conversations, I began building a community around myself. That was what was so helpful.”

- Keep safety issues in mind. Most people in support groups respect confidentiality (or, “anonymity” in 12-Step groups). However, someone leaving an abuser may wish to avoid sharing information in a group setting that could put safety at risk. Encourage people who are fleeing abuse to carry a safe cell phone with them to 12-Step or other meetings and to tell their sponsor or someone else at the meeting what is going on. (Note: Cell phones can contain GPS locator devices and pose risks for a survivor whose abuser is tech savvy.) Someone who needs to avoid being too predictable to an abuser may also want to vary the times and places of meetings attended when alternatives are available. (In larger communities, for example, A.A. may hold meetings at several different times and locations each week).

- Any peer-led support group – whether a 12-Step group or another type of group – can vary in quality, and may be healthy or unhealthy. When making referrals, find out which groups in your community are considered to be of good quality – for example, Alcoholics Anonymous groups where several of the members have healthy, long-term recovery. (Drug and alcohol counselors who are sophisticated about interpersonal violence issues may be able to recommend the safest A.A. and Narcotics Anonymous meetings.) Women who are survivors of domestic violence or sexual abuse may have difficulty setting healthy boundaries, especially with men, and many report that all-women’s meetings feel safer than meetings where both men and women are present.
- Each group – even a healthy one – has a distinct personality, depending on the make-up of the group. For example, some A.A. meetings may be small and intimate, with six or seven people in attendance, while other meetings held at popular times and locations may attract dozens of people. Some survivors may find a small, intimate group less intimidating, while others may prefer a larger group where they don’t feel as “noticed” or pressured to speak. Encourage people who want to try support group meetings to shop around for one that “fits.”
- Kasl (1992) lists the following characteristics of healthy groups: People are supported in thinking for themselves and finding their own belief system. People are regarded as whole individuals — not just “alcoholics,” “addicts,” “survivors,” or a psychiatric diagnosis. There is an established process for dealing with conflict. The group recognizes its limitations (members don’t give out medical advice or claim that the group should substitute for professional counseling or therapy). Confidentiality is respected.
- Encourage people who attend community support group meetings to recognize the limitations of such groups and to respect their own boundaries. For example, support group meetings are not meant to be a substitute for professional help, and healthy groups encourage their members to use sessions with an advocate or counselor for issues beyond the group’s scope. Some people may try to sexually exploit others in the group. Members of 12-Step groups call this practice “13th Stepping,” and most consider such behavior unethical. Also, one should not feel compelled or pressured to talk about painful abuse issues in a group setting.

Advocates may also want to partner with other providers to offer their own support groups for people with multiple issues. Because people impacted by multi-abuse trauma usually have additional safety concerns beyond those posed by interpersonal violence, support groups addressing both the interpersonal violence and co-occurring issues are essential. Moderated support groups are strongly recommended, especially for walk-in groups and for people who do not have previous experience with support groups. We have included a sample support group format and handouts in this manual.

Working with diversity

Trauma may have different meanings in different cultures. Because traumatic stress may be expressed differently within different cultural frameworks, it is important for providers

to work toward developing cultural competence (Barrow et. al, 2009). Differing patterns of caregiving across racial and ethnic groups also strongly underscore the need for culturally relevant services (Nicholson et. al., 2001).

Successful culturally competent services incorporate awareness of our own biases, prejudices and knowledge about the people we serve and their culture, in order to avoid imposing our own values on others. When working with people who are from different cultural backgrounds or who have other diversity issues:

- Get to know the groups in your community. All providers should get to know the cultures existing in their community, and seek to have diversity on their staff (Duran, 2006).
- Be aware of possible philosophical differences. For example, many providers from the dominant culture tend to promote individualism over collectivism, and many Western practitioners embrace a medical model for healing while indigenous cultures may believe that health is attained through the harmony of mind, body and spirit (Comas-Diaz, 2007).
- Recognize privilege. This includes recognition of professional power (the power differential between staff and the people who come to your agency for services). Seattle-based behavioral health specialist Karen Foley shares:

“We all need to examine our own provider biases. I think it’s important to become an ally against oppression. I’ve had to admit my own prejudices and look at all the ways I am privileged in order to better understand how I oppress, and once I can do that, I can notice the systems that keep oppression in place and take a stand against it. And then I can use my own power and privilege towards social change.”

- Be careful not to pathologize cultural differences or other kinds of diversity. And *never* imply that violence or abuse is the result of a particular culture’s norms or customs (Moses, 2010; Barrera, 2009). Shirley Moses of the Alaska Native Women’s Coalition points out that domestic violence and sexual assault are “not something that our Native culture has condoned.” Bethel advocate Daisy Barrera adds, “Domestic violence has no culture. Sexual abuse has no culture.”
- Be aware of additional issues that may make it harder to report abuse or reach outside the family or community for help, such as cultural issues or disability needs (the victim depends on the abuser as a personal attendant, for example). Shirley Moses says:

“You have women not wanting to report sexual abuse or domestic violence because they know it will totally disrupt not only their own home, but their extended family. Or it might affect their friends that they are helping. There’s a chain reaction in the village. Everybody knows what’s happening, and if a woman takes a stand and is willing to report, they are often ostracized if they leave. They are ostracized if they stay” (Moses, 2010).

- Be aware of the importance of family ties in many cultures. A survivor shares:

“As I went through the healing process more, I stopped calling my mom. Stopped calling my brothers. I instinctively cut off all communication, which is a really difficult thing to do. In a lot of cultures, it’s a big deal. In my culture, it’s a big deal. You don’t let go of your family. Your family is who you go to for support. When I pulled away, that was a big deal, but I felt an enormous sense of relief.”

- Recognize that “recovery culture,” mental health “brain styles,” physical and neurodiversity (“Aspie culture” or “deaf culture”) and socioeconomic background are diversity issues, as much so as race, gender, and sexual orientation, and need to be accommodated and respected.

A survivor of multi-abuse trauma discusses the importance of family in her culture:

“As I went through the healing process more ... I instinctively cut off all communication, which is a really difficult thing to do. In a lot of cultures, it’s a big deal. In my culture, it’s a big deal. You don’t let go of your family.”

- Communication should be age and developmentally appropriate as well as culturally relevant. For example, people with developmental issues such as FASD or autism may prefer – and need – very clear and direct communication, as opposed to the more indirect communication favored by some other groups. Referring to a *rule* as a *guideline* or a *recommendation* can be confusing for people who tend to interpret language literally (Attwood, 2007).

- Each culture has its own set of “unwritten rules” governing appropriate behavior. People from diverse cultures may or may not “know” the unwritten rules prevailing at a shelter or other agency. Staff rules may not reflect the cultural values of people receiving agency services and can induce fear, confusion, isolation and/or anger. Be conscious of the impact your worldview has on others.

- Be aware of additional safety issues that people from diverse backgrounds may need to be concerned about. For example, same-sex batterers use forms of abuse similar to heterosexual batterers but they have an additional weapon in the threat of “outing” their partner to family, friends, employers or community (Lundy, 1993). If someone has immigrant status, an abuser may threaten the individual with deportation. If a person has a disability, an abuser may threaten to get public assistance or other benefits cut off (Leal-Covey, 2011).

- Use an interpreter when necessary, including for sign language. Avoid using children, relatives of the batterer or people who do not understand confidentiality and domestic violence, sexual abuse and stalking issues (Leal-Covey, 2011). A survivor shares:

“My mom had a tough time getting things – everything was in English. She read English really well. She spoke English really well, but she wasn’t understood. So a

lot of times, people looked to me, because I was always with her, to translate for her English. Now I was a really good kid, so I didn't take advantage of that power, but I could have very easily. We tend to do that when we rely on kids to translate for their parents.”

- Confidentiality may be an even more important issue for an undocumented person. People without documentation may fear being reported to Immigration and Customs Enforcement (ICE) by law enforcement or social service personnel from whom they seek assistance (Jang, 1994). Reassure people with undocumented status that you are not required to tell ICE about them.
- To avoid reductionism or stereotypes, recognize that it is not possible to predict the beliefs and behaviors of individuals based on their race, ethnicity or national origin. In fact, one can never become truly “competent” or “proficient” in another’s culture (Chavez, Minkler et. al., 2007).

Becoming culturally competent is a life-long process and requires advocates and other providers to do their homework on a daily basis. Ask for feedback. Develop flexibility and an open mind. Addressing violence involves addressing racism, sexism, classism, ableism, homophobia and any other form of oppression that contributes to interpersonal violence.

Handling spiritual concerns

Some advocates and other professionals are uncomfortable with issues of religion and spirituality and may even distance themselves from discussions of spirituality with the people they serve. Gillum, Sullivan & Bybee (2006) state that reasons for this include lack of staff time and resources, the personal nature of spirituality, the diversity of religious or spiritual beliefs among individuals, and apprehension about creating misunderstanding or intruding on an individual’s privacy. The result, they point out, may be that “the shelter provides a haven for physical safety, but fails to provide an environment for spiritual healing.”

Interpersonal violence creates a spiritual crisis for many victims. The experience of being hurt by someone they believe should love, cherish and protect them (whether a partner or a parent) often causes victims a great deal of spiritual distress, which can manifest itself in various ways – feelings of despair, belief that life is meaningless, or perceptions of oneself as powerless (Gillum, Sullivan & Bybee, 2006). If, in response to the violence, the victim does something that violates their previous beliefs, this can heighten the sense of spiritual crisis. A survivor who was sexually assaulted when she was in high school shares:

“The sexual assault did result in a pregnancy and then I had an abortion. Being Catholic, I had a horrible amount of guilt and shame to deal with. I remember in college having a lot of late nights of deep depression and sorrow, and calling home and crying, and saying, ‘I’m losing my mind. You need to help me.’”

Unfortunately, it also is not unusual for abusers to twist and distort spiritual or religious teachings to justify their violence. A survivor shares:

“He said: ‘This is your fault. You’re making me do this. God is going to hate you. You’re going to go to hell.’ He said all the things that were my biggest fears at that time. He said I was making him do this, and then, it felt like I was making him do this. It felt like it was my fault.”

At the same time, many people, especially those from marginalized groups, view adherence to spiritual practices as resilience against adversity (Comas-Diaz, 2007). Naomi Michalsen, Executive Director of Women In Safe Homes in Ketchikan, AK, says:

“I think the word ‘spiritual’ or ‘spirituality’ kind of throws a lot of people off. It does me, even. But I feel like everybody has that part of them, and they need to work on that part as well as all the other things. It has to be part of the healing somewhere. For a lot of Native people, I believe that learning about their culture is spiritual, because it’s something that we’ve lost and we long for” (Michalsen, 2007).

Many survivors of trauma have found their spiritual beliefs or their spiritual community to be a source of strength in times of trouble, and critical to recovery and healing.

A survivor shares:

“I would say the one single thing that helped me the most, throughout my life, my survival, was my spirituality. I believe that if I pray, somebody is going to listen.”

For one survivor, a familiar religious ritual was critical to helping her cope when she was a child whose father often beat her mother and then abused her as well:

“She [a next-door neighbor] let me know that God would hate the abuse, that God loved me. She gave me a rosary and taught me how to pray the rosary, and she set up a plan for me. She said she wanted me to go home and find places where I could hide where my father wouldn’t find me, and to take the rosary with me and pray. So I did. I would go home. I would find those hiding places. After a while, I was wearing the rosary so I could go at any time.”

For another survivor, her spirituality was an important source of empowerment:

“Spirituality is very important. I’ve gone through the tundra and I’d say, ‘Where are you? Be near me. Where’s that light?’ Because I can feel the light. I’ve been told that when I speak, I give this radiance – and I can feel it right now. The power. The radiance. It’s like an electricity that comes out of my body. Because I’ve dealt with my issues, and I’m like a guiding light that is full of power. The ray that I give out, I can’t describe it, but I can feel it.”

People exposed to chronic or repeated traumatic events may feel an especially strong

need for a spiritual connection. Often these victims develop a fundamental sense of alienation from themselves, other people, and spiritual faith as a result of feeling permanently damaged – they may experience existential or spiritual changes in their view of the world, including loss of faith in humanity or a sense of hopelessness about the future (Herman 1997, 2009).

One survivor shares that a sense of spiritual connection literally kept her alive:

“I needed to find connection, a sense of belonging, belief in the human race, that kind of stuff, and the spiritual help – connectedness, the meaning of life. When I couldn’t do it for myself, I’d think about my nephews and my niece, children in my life. Okay, I’ve got to do this for them. Keeping those connections for me was more important initially, because I was suicidal at the end.”

Given the importance of spiritual concerns for many trauma survivors, Gillum, Sullivan & Bybee (2006) offer suggestions for advocates wishing to provide an environment that accommodates spiritual needs without being intrusive:

- Respect spiritual needs by providing free time for attendance at church services.
- Make a quiet room available for prayer or reflection.
- Invite spiritual leaders to attend trainings that provide education about interpersonal violence and the dynamics of abusive relationships, as well as the experiences and needs of victims and survivors.

To label or not to label?

Labels: Are they oppressive? A necessary evil? Empowering?

Few things have been more controversial in the helping professions than the use of labels. Some advocates and other professionals are opposed to the use of any kind of label for any reason, while others consider labels a necessary evil, and still others consider labels to be a valid therapeutic tool and encourage individuals who seek their services to adopt them. Individuals so labeled can have a range of reactions as well. Some find labels of any kind to be oppressive while others consider certain labels to be empowering or liberating.

Most will agree that labeling can have negative consequences, especially when misused. Here are some of the possible drawbacks:

- Perhaps the biggest negative consequence is stigma. People with certain labels may find it more difficult to obtain employment, housing or social acceptance.
- A label can lead to stereotypes. The person with the label often becomes “Other” in the

eyes of those applying the label. People may start to underestimate the individual's capabilities or intelligence.

- Once a person acquires a label, there is often a tendency for others to view everything the person does through the prism of that label. Everything the person does becomes pathologized. Duran refers to a DSM-IV psychiatric diagnosis as a “naming ceremony” in the negative sense. One survivor of multi-abuse trauma shares:

“Once you stick a label on me, it's like the usual rules of human interaction don't apply. Instead of the give and take expected of adult relationships, you can set yourself up as the standard and insist that I meet it, rather than meeting me halfway. You can lecture me to consider your feelings, but you don't need to consider mine because my feelings are probably inappropriate anyway. The same behavior gets described in a completely different way depending on whether you do it or I do it. For example, if you don't agree with me on some issue, it's a case of honest disagreement. If I disagree with you, I'm 'defiant' or 'oppositional.' I'm not expected to meet you halfway, I'm expected to twist myself into a pretzel trying to be you.”

- Others may accuse the person with the label of using a “fad” diagnosis to avoid accepting personal responsibility for their behavior, or as a shortcut to privileges or entitlements, or to get attention or sympathy.
- Some argue that labeling promotes the formation of a negative self-identity, one that overemphasizes limitations and ignores strengths (Evans & Sullivan, 1995).
- Labeling may encourage individuals to think of themselves (and encourage others to think of them) as being only their disorder or their disease, and this may increase their exposure to the negative effects of the stigma still associated with these labels (Evans & Sullivan, 1995).
- A label often does not capture the full story about a person's experience. A survivor shares:

“We're not 'serious mental illness' individuals. The bottom line is, we were simply hurt as human beings. You can't attach labels or create words for someone who was totally wounded.”

However, some believe that labels can be beneficial under certain circumstances:

- A label can help an individual get needed services or accommodations. For example, insurance companies usually require a DSM-IV diagnosis before providing reimbursement for therapy or counseling services. People with disabilities must inform employers of their need for accommodations in order to invoke the Americans With Disabilities Act.

- In some cases, a label can actually serve to reduce stigma – for example, viewing alcoholism as a disease rather than as a moral failing. Evans and Sullivan (1995) argue that labeling is a universal human activity and will occur no matter what anyone wants. They point out that individuals who seek our services have already labeled themselves or have been labeled by others, in one way or another, as “bad,” “shameful,” or “weak.” These individuals may well feel that a diagnostic label is preferable to the labels they’ve already been getting, such as “lazy” or “stupid.” A survivor shares:

“I’ve spent a lifetime collecting some really negative labels. When I was a child, the labels were mostly screamed at me: ‘Stupid! Stubborn! Lazy!’ When I married an abusive man, he labeled me a ‘bitch,’ ‘whore’ and ‘slut.’ When I began using alcohol and drugs to blunt the pain, the labels changed to ‘lush’ and ‘druggie.’ When I was arrested for disorderly conduct following a series of domestic violence incidents, I acquired another label: ‘offender.’ I know there are people in the helping professions who would like to eliminate diagnostic labels, but I must say that being told I have ‘the disease of alcoholism’ beats the heck out of getting called ‘lush,’ ‘slut,’ ‘criminal’ and so forth.”

- Knowledge is power: A diagnostic label can help some survivors make sense of their experiences. For example, labeling a person’s experience as “complex trauma” or “multi-abuse trauma” can help the individual see certain behavior as a coping mechanism rather than as an indication of defective character. Herman (1997) points out that traumatized people are often relieved simply to learn the true name of their condition because it gives them a language for their experience, and allows them to begin the process of mastery. Once a problem has a name, one can develop a plan to address it.
- A label can help clarify thinking and move people out of denial – either individually or as a society. Consider, for example, how societal reactions begin to change when people stop calling certain situations “a lovers’ quarrel” or “a date gone wrong” and start labeling them “battering,” “sexual assault,” and “domestic violence.”

So how does one resolve the issue of labels?

- Evaluate what function the label serves. Ask the survivor whether a certain label serves a useful function or not. The decision to use a label or not should depend on the individual’s needs and preferences.
- Distinguish between labeling a person and naming a problem. Naming the problem or issue or experience can be empowering and liberating. Labeling the person often oppresses and disempowers.
- Evans and Sullivan (1995) suggest that when stigma and stereotyping are attached to certain labels with a valid therapeutic purpose, the task is either to change the negative connotations of these labels or to adopt labels with a more positive but still realistic tone.

Defining success

Advocates and other providers may need to rethink the way we define success when working with people who are survivors of multi-abuse trauma and who struggle with multiple issues.

Be aware that “success” may mean different things to different people. Courtois, Ford and Cloitre (2009) point out that all people do not heal the same way – what might seem like a partial success for one individual might meet another’s full capacity:

“Some people who have survived multiple traumas never progress beyond life stabilization and/or sobriety, and this is a sufficient and valuable attainment if it is meaningful for them, a genuine victory, and a profound change of life even if no further change is undertaken.”

For example, some people with disabilities may be employed but still need some degree of subsidized housing or public assistance to pay for medication, and may continue to need this assistance for the rest of their lives. Does this constitute success? What about a person with mental health issues who will require medication or even periodic counseling for a lifetime, but otherwise holds a job and lives independently? How about a person who, instead of leaving a domestic violence shelter to move into an apartment, checks into a long-term residential drug treatment program after recognizing problems with alcohol or drugs? How about a woman at a domestic violence shelter who decides to go back to her abuser until she finishes school and can get a better-paying job – only now, she has a safety plan and has enrolled in school and can see a way out of her situation? Or a person with substance use disorder who still smokes cigarettes but has managed to stop drinking alcohol or using illegal drugs? How about someone who chooses to move up the career ladder at a fast-food restaurant rather than enroll in college? Erin Patterson-Sexson at S.T.A.R. in Anchorage says:

“I’m not going to base it on whether she gets a job or keeps a job or goes to college. None of those things are as important to her as they are to other people. But I’m going to pay attention to the way she’s starting to perceive herself and her quality of life in this world” (Patterson-Sexson, 2010).

She adds that she is often more concerned with how the people she serves come to view themselves and their experiences:

“My goal is to firmly plant the seed that no matter what you’ve dealt with and overcome, you are worth it. You can feel happy. You can get to a place where you feel at peace with your experiences. I want to teach women that it’s okay to be pissed off and it’s okay to be angry and to feel betrayal and to not run and hide from those feelings. I want to teach women healthy options to cope. And if anything, I just want to teach them that they are teachable and they are capable and I don’t care what they’ve dealt with in their lives, they are not ruined. If I can help plant this smallest of seeds within them, then I’ve done my job” (Patterson-Sexson, 2010).

SURVIVORS SHARE: WHAT IS SUCCESS?

“Success” means different things to different people. Several survivors shared with us what helped them feel successful, and when they began to feel that they were addressing their issues effectively.

For one survivor, the journey toward success began when she found a place and some people she trusted would really offer her the right kind of help: “I knew things were turning around when I began to feel hopeful. I wouldn’t say that’s the same as successful, but once I got the right service, I found the place where I felt accepted, where I felt encouraged, and it was going to be okay. And it’s been a work in progress since then. I feel like I’m beginning to reach that point of mastery, where I can be successful in life, in relationships, in my being able to trust other people, being able to care for myself financially, all those kinds of things. I could not do those things 14 years ago.”

For another, her sense of success began with her ability to open up: “I couldn’t open up. I couldn’t say anything. When I did, what a big difference! When you do open up, I can equate the resemblance to when you have a cut in your finger, you bleed and that’s how the inside evolves – taking out all that garbage, all the hurt, all the memories of what I experienced in life. Then my heart turned into gold. The gold I’m talking about is compassion for others. I can feel others when they’re hurting because of the heart of gold I have in me.”

One survivor said education helped her feel successful: “I was able to leave that relationship after 10 years, and then I went to where my father lived. I stayed with him until I got divorced. Then I started to go to school. I worked full time, went to school full time and I was still on welfare. But I did that for several years and got a degree. But it all started, I think, with the education and just learning. I’ve been able to get to a point where I feel good about myself. I feel good about what I’m doing. It’s not just me, but my children and even my mother and my grandmother. It’s like this whole thing has been able to open up, even with the elders, which is really neat to see. My healing is still ongoing.”

And another survivor began to recognize her own strength: “After a while, I came to appreciate what I did to survive. Then I had a renewed sense of confidence. Not only did I survive all this, but I went to college, I went to law school. I totally live a really good and full life. The violence I’ve suffered in my life is not all of who I am. It’s a part of my life. I took back a lot of it. I can have dogs, which is a really big deal. I can live on a farm. I can go camping in the woods. I can do all sorts of things that I never, ever imagined I’d be able to do.”

Cindy Obtinario at New Beginnings says it’s important to celebrate “baby steps” as well as big achievements:

“With someone who’s doing self-harm, it might be that they haven’t done that for the past month. I think our job as advocates and practitioners is to really support and help them see that. You did something different. You picked up the phone. You called somebody. Celebrating those ways that they have succeeded is empowering. It’s important for us to do that” (Obtinario, 2010).

As partners in a survivor’s journey to safety, sobriety and wellness, we need to celebrate all victories, including the baby steps, whether or not they meet the larger society’s definition of success. And we may need to work harder to get this message across to funders and the public.

How to avoid re-traumatizing the people we serve

People with multiple trauma issues who seek help from social service agencies sometimes end up being re-traumatized by the very system that was supposed to help them. As stated previously, difficulty accessing appropriate services creates its own trauma. A survivor shares:

“In one situation, where I went through a domestic violence kidnapping, I ended up having to report my case to the state patrol, and then two different county sheriff’s offices that were two hours away from each other. First I reported to the state patrol. I went through all this spiel, thinking I’m getting help. It’s so hard to tell your story anyway. In a nutshell, he basically said, ‘I’m sorry that happened to you, but you need to tell this story to the County Sheriff’s Department. So then I’ve got to get up the gumption and the transportation and the fortitude to go to that county sheriff’s office and then report it. So I went there and they said, ‘Well I’m sorry that happened, but you need to report that to the county where you were abducted to.’ That was two hours away. When I go to report for the third time, they said, ‘I’m sorry that happened to you, but do you really want to face him in court? Because all we can get him for is damage of your property and stealing of your leather coat and your stereo. And do you really want to face him in court over that?’ Now keep in mind that this man had forced me to drive, had his arm around my neck, his foot over my foot on the accelerator, and we were driving on winding logging roads, and then he was pulling the emergency brake and making the car spin out. On one side was a very deep lake, and on the other side of the road was the side of a mountain. But the other thing they could get him for was theft and damage. He broke my windshield. I finally ended up getting away from him when he got intoxicated. I snuck away, and got away from him and that’s what they told me. So when I had domestic violence later on in my life, was I going to call the police right away? I think not. It took nearly a year after my domestic violence assault before I reported it to police.”

When social service fragmentation leads to people being passed around to numerous providers, these individuals may be left with the feeling no one cares about them or wants to deal with their issues. A survivor shares:

“I couldn’t seem to find a provider who would hear my entire story. It was like, ‘We can deal with this little piece of you, but please don’t bring in all these other things, because it’s too complicated.’ Well, by golly, people are complicated. If you’re trying to get what you need from the social service system, you can begin to feel like you’re being cut into little pieces.”

As individuals revolve around the system, acquire multiple labels and become defined by those labels rather than viewed as human beings, they find it even more difficult to address their issues.

For many survivors of trauma who have psychiatric issues, or who have other disabilities, systems of care perpetuate traumatic experiences through invasive, coercive or forced treatment that causes or exacerbates feelings of threat, a lack of safety, violation, shame and powerlessness (NCTIC, n.d.). Some practices may even seem to replicate the behavior of the original abusers.

Here are some things to keep in mind to avoid re-traumatizing people coping with both interpersonal violence and other issues:

- Avoid judgmental attitudes. People do *not* choose to develop multiple abuse trauma issues. Believe that domestic and sexual violence, substance use problems and mental health issues are traumatic and painful. Believe that people do their best to survive. Assume the attitude that people who seek your help are doing the best they can and want what is best for themselves and their families (Trujillo, 2009). A survivor shares:

“My mom is a very private, very proud person and is only going to accept certain types of help. That help came from a church and our school. And the reason she accepted them was because they recognized her strengths. So they approached her by saying, ‘We can tell that you care a lot about your children. We know that you want them to have a good education and we can help you with that through free tuition. We can help you get them uniforms for school. We can help you get textbooks for school. We can help you by providing them breakfast if you bring them to school early.’ Because they approached her that way, it made her feel like they were helping *her* help us. Not that they thought she wasn’t doing a good job. That was really, really important to her.”

- If lack of appropriate training or credentials prevents you from answering a question or providing a certain kind of assistance, explain this to individuals seeking your help. Make an appropriate referral and emphasize that they are not wrong for coming to you with this particular problem. Make it clear that you will help them figure out who can provide the needed help and are happy to explore options with them.
- Acknowledge controversial issues. When advocates and other providers are in conflict with each other over theoretical issues or philosophies, people with co-occurring issues can get caught in the middle. When program staff refuse to acknowledge the controversy – or worse, accuse an individual of manipulating by pitting one advocate or provider against another – this creates frustration and confusion for the person seeking help.

A SURVIVOR OF MULTI-ABUSE TRAUMA SHARES HER SUCCESS STORY

I went to treatment at 26 years old because my addictions had put me in the hospital. I was the only woman who started my residential stint with ‘a happy marriage to a good provider.’ I had a lovely child, a home, a family that supported me and two vehicles that worked. I went into treatment with ‘a little problem with cocaine.’ Before I left treatment I was labeled as an alcoholic-drug addict with incest issues and had to go to 12-Step meetings, continuing care and a mental health provider several times a week. After going home I had another label, domestic violence victim (verbal and sexual abuse) and moved into the women’s shelter.

Within two months of getting help for my ‘small cocaine problem’ I was penniless, had no transportation, realized I sucked at parenting, had not been employable for several years, was full of terror and rage from the incest issues and living in a small room with my 3-year-old and my cat in a house full of women fresh out of their own trauma. I didn’t drink, I didn’t use and I didn’t cry myself to death. The shelter had a night advocate in recovery who lived at the shelter, and took me and the other ladies in early recovery to 12-Step meetings. They had parenting classes and incest survivor classes and support groups, and a program that helped me to see I was a worthwhile human being. They had made sure I could attend my aftercare groups and see my mental health therapist.

I stayed at the shelter for 6 months, and I know without a doubt if they were not there, or didn’t work with the other agencies and offer support that I needed, without labeling or judging me, I would not have made it. I stayed sober. I stayed sane. I eventually sponsored women in recovery, taught parenting classes, helped other incest survivors by starting a non-profit agency, became a victims’ advocate, child advocate, sexual assault advocate, and then became a substance abuse counselor and Native victims’ advocate. Today I have 21 years of sobriety, am about to complete my bachelors in social work and have reconnected with my Native heritage. I plan to obtain my Masters degree and then ... who knows ... I could be a Native recovering drug addict-alcoholic, incest survivor, domestic violence survivor with a Ph.D.

- Find ways to integrate or reconcile the philosophies employed by many substance abuse counselors, mental health providers, victim’s advocates, social workers and other providers to ensure that people coping with interpersonal violence (e.g. domestic violence, sexual assault, stalking), past trauma and various co-occurring issues can use services safely and without confusion.
- Provide clear communication. If there is any kind of sanction or consequence imposed by staff for doing or not doing something a certain way, then we are talking about a *rule*, a *requirement* or a *policy* and should not use language that implies “optional.” Referring

to a *rule* as a *guideline* or a *recommendation* can be confusing, especially to people on the autism or FASD spectrums, who may tend to interpret language literally (Attwood, 2007). A survivor of multi-abuse trauma shares:

“I think most people – including people seeking services from a social service agency or a shelter – are willing to abide by a few reasonable rules, with the emphasis on ‘a few’ and ‘reasonable.’ Authoritarian, to me, is when we have dozens of these rules, there are no exceptions, even when one is clearly called for, and we’re told we don’t need to know the reasons for them.”

- Developing program guidelines is generally more empowering than enforcing a litany of rules. However, the term “*guidelines*” implies flexibility. Such terminology should not be misused to mask authoritarian practice, nor to disguise or hide a rule. Doublespeak is a tactic of abuse. Use the term “*guidelines*” only when your policy truly provides a range of options. A survivor shares:

“There are few things more infuriating than being punished or sanctioned for not doing something that was supposedly ‘optional!’ I think it’s good to have staff who want to avoid being authoritarian. However, instead of using ‘hedge’ language, staff worried about sounding authoritarian may wish to actually keep their rules or requirements to a minimum and ask themselves how many of these are really necessary. If a policy does seem necessary, then be willing to explain why and be willing to make an exception where one is called for.”

Things to think about as we develop patience and empathy

Change often happens slowly, and it may take people several tries before they succeed in leaving an abusive partner or achieving sustained recovery from substance dependence (IDHS, 2000) should either, or both, be their choice. People with psychiatric illnesses, physical or developmental disabilities or extenuating circumstances such as poverty or homelessness may need longer to achieve goals. Cindy Obtinario observes:

“Each woman has her own process, and the more issues she has, the longer it takes. If you have chemical dependency, mental health issues, intergenerational trauma, or child sexual abuse – the more issues you come to the table with, the more complex healing will be. And we are a society of quick fixes. We get a headache, we take a pill and it’s supposed to be gone. Hurry up. Instant, instant, instant.”

If we find ourselves getting impatient with a survivor’s progress, it may help to consider the ways this person’s life is different from ours. What seems easy or obvious to us may not be easy or obvious to someone coping with multiple issues at once. A survivor of multi-abuse trauma may face barriers that we don’t even think about. For example:

- She may have no car, no money, no phone.

- She may not know about available resources.
- She may be unable to read. Many people who are illiterate feel shame and won't admit this. But inability to read or write would make it hard or impossible to do some assignments or fill out forms.
- A mental health issue such as depression, or a developmental issue such as autism or fetal alcohol spectrum disorder, may make it hard to stay focused, or accomplish even simple tasks – especially if a person has not received appropriate services or has stopped taking medication because it costs too much.
- Medications may have unpleasant side effects, and don't always work right away, which can be discouraging.
- Because the social services system is so fragmented in many communities, bureaucratic paperwork, policies and procedures can be confusing to the point of mind-boggling, and extremely frustrating.

Expanding our definition of advocacy

We may sometimes need to expand our idea of what advocacy means when serving someone who is overwhelmed by multiple issues. Cindy Obtinario, Chemical Dependency/Domestic Violence Specialist and Women's Advocate at New Beginnings in Seattle, WA, shares:

“Keeping in mind the empowerment philosophy advocates in the domestic violence field share – we believe each woman solves her own problems in her own way and time – I also believe it is important for us to remember there are people who may need a bit more. Sometimes, when one has chemical dependency or mental health issues or complex PTSD, and we use a model requiring self-advocacy, a survivor experiencing multiple barriers might at that moment say, ‘Just forget it. Never mind. This is too difficult.’

“I think we need to be aware that the more barriers a woman has, the more support and advocacy we might need to provide. Not doing it *for* her, but *with* her by saying things like, ‘It looks like you're having a hard time with this right now. Come on into my office, and we can make these phone calls together.’ With advocacy presented this way, she can dial the numbers with me sitting here, knowing she has somebody who cares. She has the comfort of knowing she has someone there who supports her through her process.”

SAFE AND SISTR: EVERYONE WELCOME HERE

Safe and Fear Free Environment, Inc. (SAFE), in Dillingham, AK, is one example of a program that goes the extra mile to be accessible to people with multiple trauma issues and multiple needs. SAFE is Bristol Bay's shelter and advocacy agency for domestic violence and sexual assault victims. Dillingham, a community of 2400 people, serves as a hub for as many as twenty-five surrounding villages and has a geographic service area approximately the size of Ohio.



Few roads connect Bristol Bay villages, so transportation is accomplished mostly by plane or boat. The nearest metropolitan city is Anchorage, 315 off-the-road miles northeast of Dillingham. Three air carriers provide jet transportation between Anchorage and Dillingham, while smaller planes provide transportation between villages and to and from Dillingham.

Isolation poses special challenges

SAFE's closest sister agencies are in Unalaska (Unalaskans Standing Against Family Violence) and Bethel (Tundra Women's Coalition). Unalaska is at the beginning of the Aleutian chain and Bethel is northwest of Dillingham at the mouth of the Kuskokwim River. In between SAFE, USAFV and TWC is lots of land and water, where isolation can create additional barriers for people seeking to escape violence.

Breaking the barrier of isolation is paramount for people who experience domestic violence and sexual assault in rural Alaska and can be costly and logistically challenging. SAFE provides crisis line services, transportation, shelter and legal advocacy for the people the agency serves.

Domestic violence and sexual assault are common and overwhelming problems in Bristol Bay. In any given year, nearly 20 percent of adult female residents of the Bay receive services from SAFE. Another 10 percent will go through the police and courts without ever

contacting SAFE. However, domestic violence is substantially under-reported, and staff members believe it is conservative to estimate that three out of 10 adult women in Bristol Bay will be victims of domestic violence sometime this year. The average number of children in households of women who seek services from SAFE is three – most are under the age of 10.

Another challenge: Cultural barriers

Alaska Native women comprise less than 5 percent of the population, yet make up nearly 60 percent of reported sexual assault victims. Nearly one-third of the women in shelters in urban areas of the state are Alaska Native women.

Cultural disruption is associated with increased violence against women among Alaska Native groups, and Bristol Bay is no exception. Prior to Western intrusion, some Native groups were egalitarian, some matriarchal, and some patriarchal; however, status depended more on the individual's ability to contribute to the group than on gender. Violence against women was not the norm for any Alaska Native group. Native Alaskans interacted through extended families, provided for their basic needs from the land and sea, educated through oral tradition, and focused on communal needs.

Throughout its 20-plus years of service to Bristol Bay, SAFE has identified major barriers to victims of violence attaining either short- or long-term safety. Western culture generally requires a lifestyle of nuclear families, wage earners, formalized education, and a focus on individual needs. Today, while many rural Alaskans still depend on subsistence, the cash system is necessary for most basic needs.

Television is available throughout the state, which has further undermined traditional Native values. Many Elders have lost their place of honor and respect. Being forced to reconcile Western culture with their own has led to high suicide rates, chronic alcoholism, and increased violence against women and children. SAFE's commitment to reduce these barriers led to the birth of the SISTR Program.

More challenges: Addressing multiple issues

The Safety in Sobriety Through Recovery Program (SISTR) came about when the local shelter director and the local treatment provider sat in a maqiq (*Yupik name for steam bath*) and pondered how to reduce barriers for the people they both serve in the remote Bristol Bay area of Alaska. The SISTR Program was designed to meet the needs of women and children over 12 years of age who are or have been served by SAFE, or who live in the Bristol Bay region and have been affected by violence, alcohol and/or other drug use and are seeking help.

Housed at SAFE, onsite substance abuse counselors provide outpatient services and provide access to other agencies as needed. Advocates at the shelter provide safety planning, shelter, advocacy and child-care for women to attend intensive outpatient (day) treatment at Jake's Place, the Bristol Bay Area Health Corporation residential alcohol/drug program where the counselors also maintain an office and are part of the regular treatment team.

SISTR and SAFE can help with crisis intervention, emergency transportation, advocacy and support, legal advocacy, medical and court accompaniment and safe shelter. SAFE also provides a 24-hour crisis line, information and referral, videos and reading materials. Most importantly advocates listen, offer support in a nonjudgmental manner and prioritize accommodating everyone they serve in an empowering, non-coercive, practical manner.

SISTR serves both single women and women who face barriers due to child-care responsibilities. Education on the combined impact of domestic violence, sexual assault and alcohol and other drug abuse is provided in a culturally relevant manner with a focus on safety, autonomy, freedom from fear, empowerment and justice.

Offering trauma-informed services

SAFE is committed to providing trauma-informed services rooted in the experience of survivors of domestic violence and sexual assault as well as that of recovering women. Rules are kept to a minimum and advocates provide accommodation as needed.

SAFE has developed tools to reduce barriers for shelter residents and other people they serve who experience Fetal Alcohol Spectrum Disorder and/or behavioral health issues. Individuals experiencing cognitive disabilities have access to information in multiple formats. Pictures are used to communicate complex steps and information is provided in manageable chunks.

Among the excellent resources developed by SAFE are the videos “*The Heart of the Grizzly*” and “*The Woman and the Moon.*” These videos portray the experiences of survivors of sexual assault and domestic violence in rural Alaska.

Ongoing programs for women also include:

- ***Maintaining Our Mothers’ Sobriety (MOMS)***: Evening child care for parents in aftercare treatment or attending support groups.
- ***Ending Violence in Our Lives through Validation and Empowerment (EVOLVE)***: Services for women who have resorted to using violence in their lives or relationships.
- ***Thursday Night Support Group***: Dinner, Talking Circle and Maqiq (steam).

For more information about SAFE or the SISTR Program contact: Ginger Baim or Karen Carpenter, SAFE, P.O. Box 963, Dillingham, AK 99576. Email: safe@besafeandfree.org. Website: www.besafeandfree.org. Office Phone: 907-842-2320. Fax: 907-842-2198.

A CLOSER LOOK AT INDIVIDUAL ISSUES

This section provides more detail about some of the co-occurring issues faced by people who are survivors of multi-abuse trauma.

Advocates and other service providers are sometimes reluctant to ask about certain issues, lest they appear to be blaming victims for violence perpetrated against them. One of the fundamental principles of the advocacy movement, after all, is the belief that individuals do not experience violence or abuse because of mental illness or because of some kind of problem, behavior or pathology on the part of the victim (Ferencik & Ramirez-Hammon, 2011).

Advocates may also be anxious about the stigma attached to certain co-occurring problems, as well as the potential consequences to the survivor if knowledge of the issue gets into the wrong hands. For example, there is the risk that an abuser could use the situation in court in an attempt to gain custody of children.

It is vitally important to emphasize that people who experience domestic violence, sexual assault or other violence neither “ask for” nor deserve violence or abuse – no matter what else is going on. The most important message you can give a person whose experience includes multiple abuse issues is, “This is NOT your fault.”

This message is especially important if individuals were under the influence of alcohol or drugs, were experiencing psychiatric symptoms, or were coping with other co-occurring issues at the time an abuser took advantage of and hurt them.

However, this does not preclude us from addressing co-occurring issues. If we do not acknowledge and address other issues an individual may be facing, we miss crucial opportunities to help the people we serve to get safe and heal from violence and abuse.

And we can – by our silence – inadvertently contribute to the sense of stigma attached to certain issues, as well as to the re-traumatization from the social service system experienced by a survivor who is unable to access the right kinds of help.

Advocates must be very mindful of confidentiality concerns and a survivor’s right to privacy, autonomy and safety. When addressing co-occurring issues, providing advocacy, accommodations and referrals can be very helpful. But it is important for advocates to refrain from listing a specific referral or making notes in someone’s chart that are labeling, diagnostic or that could be used against the individual.

As a matter of policy, advocates should refrain from writing notes in an individual’s file or log whenever possible. This is particularly important since notes can be subpoenaed and could put the people you serve at risk.

On the following pages, we take a closer look at several of these co-occurring issues: complex trauma, substance use disorders, mental health concerns, disabilities, societal oppression, intergenerational grief and historical trauma, poverty, homelessness, sex trafficking and incarceration.

Included are the role trauma plays in each of these issues, the special safety concerns surrounding each issue, barriers each issue may pose for survivors of multi-abuse trauma seeking safety or services, how staff can empower survivors coping with each issue, and suggestions for working with other providers.

COMPLEX TRAUMA

Mental health professionals in recent years have begun to speak of *complex traumatic stress* or *complex psychological trauma* (Courtois & Ford, 2009), *complex posttraumatic stress disorder* (Herman, 1997, 2009), and *complex trauma* (Warshaw, 2010) that can result from prolonged and repeated abuse, especially if the abuse began in early childhood or came from multiple sources.

Some experts distinguish between “Type I” trauma – resulting from a single incident such as a serious car accident, a natural disaster, or a one-time episode of abuse or assault – and “Type II” complex or repetitive trauma resulting from child physical or sexual abuse, severe domestic violence or community violence that is ongoing and chronic (Courtois & Ford, 2009).

The histories of people with complex trauma generally include a variety of abusive experiences across the life cycle rather than a single act of abuse (Warshaw, 2010). That is, they live in chronically abusive environments that combine varied types of abuse and neglect. As children they often experienced combinations of emotional, physical and sexual abuse; parental substance abuse; being a witness to domestic violence; having a parent or parents with psychiatric illness; and/or incarceration of a parent (Kinsler, Courtois & Frankel, 2009).

Social marginalization and oppression are likely to exacerbate or complicate complex trauma symptoms (Briere & Spinazzola). Courtois and Ford (2009) list several cumulative adversities faced by individuals, communities, ethnocultural minority groups and societies that may lead to – as well as worsen the impact of – complex trauma. Some of these include living in an impoverished neighborhood; incarceration; homelessness; having physical, developmental, intellectual or psychiatric disabilities; being sexually or physically re-victimized as children or adults; and victimization through political repression, genocide, “ethnic cleansing,” torture or displacement.

Judith Herman (2009) emphasizes two major points about complex trauma:

- Such trauma is embedded in a social structure that permits the abuse and exploitation of subordinate individuals or groups.
- Such trauma is relational. It takes place when the victim is in a state of captivity, under the control and domination of the perpetrator.

Effects of complex trauma

Because of its extreme nature, complex trauma can have a profound impact on an individual’s personality development and basic trust in primary relationships (Courtois &

Ford, 2009; Warshaw, 2010). Herman (1997, 2009) lists several common long-term effects of complex trauma on survivors:

- *Emotion regulation problems.* People with complex trauma often experience difficulty managing their emotions. They may experience severe depression, have thoughts of suicide, or have difficulty controlling their anger. They may experience numbing, or an absence of emotions other than anxiety, guilt, shame and sadness.
- *Changes in consciousness.* Following exposure to chronic trauma, a person may repress memories of the traumatic events, experience intrusive flashbacks, or experience dissociation.
- *Somatization.* Survivors of complex trauma may experience unexplained physical pain or medical problems.
- *Changes in expectations regarding personal relationships.* People who have been repeatedly traumatized often expect to be assaulted, betrayed, exploited or abandoned by significant others, or people to whom they turn for help, because this has been their lifetime experience.
- *Spiritual alienation.* People exposed to chronic or repeated traumatic events may develop a fundamental sense of alienation from themselves, other people, and spiritual faith as a result of feeling permanently damaged. They may experience existential or spiritual changes in their view of the world, including loss of faith in humanity or a sense of hopelessness about the future.

A survivor shares her experience with dissociation:

“I was being sexually abused from as far back as I remember. My first memory of sexual abuse was when I was three, when my father raped me. At the point that I felt overpowered by him, I panicked, and my mind automatically and instinctively separated itself from my body. I dissociated. I went up to the ceiling. I went as far away as I could from what was going on and watched, as if it was happening to someone else. It looked like me, but it wasn’t me. So I didn’t feel the panic. I didn’t feel the physical pain or the emotional pain.”

Another survivor talks about feelings of being “damaged”:

“The first time I was abused sexually, my parents went to a convention, and had some friends babysit us. I was the oldest. I remember there was drinking and it was two males. They were brothers. I remember waking up and the man’s hand was touching me, and I took his hand off, and it wasn’t too hard to get away because he was almost passed out. I don’t know why I did this, but I grabbed the rest of my brothers and sisters. And I remember my younger brother, who was out in the kitchen with this other man, was being abused sexually. So I remember taking them all and going to a neighbor’s house. I don’t remember anyone telling me not to say anything, but the neighbor came in and they cleaned everything up, put the booze out

of the house, picked up all the cans, cleaned up the house. So I don't know if that gave me the message that I wasn't supposed to say anything, or it was my fault. So I had that happen, and I attribute that to the way I felt about myself – like I was dirty, or it didn't matter anymore.”

People with a history of complex trauma have a higher risk for medical conditions, substance abuse and mental illness (Pease, 2010). Physical problems such as irritable bowel syndrome or fibromyalgia are also common, but often dismissed by physicians as “not real” or “all in one's head” (Leal-Covey, 2011).

A lack of response or protection, secrecy, denial or victim blaming from people in a position to help the victim can severely exacerbate the impact of trauma. This circumstance has been labeled the *second injury* or *betrayal trauma* (Courtois & Ford, 2009). Strengths and resilience factors can mitigate these effects.

Resilience is the capacity for successful adaptation despite challenging or threatening circumstances (Warshaw, 2010). Resilience factors may include having the support of caring adults or peers, ability to engage other people, and ability to access resources (Pease, 2010). The response of caring adults can play a large role in the degree of resilience an individual develops. A survivor shares:

“My next-door neighbor, because we lived in a duplex, could hear that my father was hurting us. She'd hear my father yelling at us. She'd hear us crying and screaming. So when my mom went to work, instead of leaving me at home with my father, she arranged for me to go next door and stay with this 72-year-old woman. She had very little education. She grew up in the fields of El Salvador. She was totally a gift, and she would never, ever have known that. She was an incredible influence on my life. She let me know that she could hear what was happening in our home, and she let me know that what my father was doing was wrong.”

Barriers to service

Survivors of complex trauma face particularly tough barriers when they try to get the right kind of help from the social service system:

- Because of the number and complexity of their symptoms and issues, survivors of complex trauma often receive services that are fragmented and incomplete. All too commonly, neither the provider nor the person seeking help recognizes the link between the presenting issues and the history of chronic trauma (Herman, 2009).
- Certain behavior may pose challenges for advocates and other providers. Because of their characteristic difficulties in close relationships, survivors of complex trauma are particularly vulnerable to revictimization by caregivers. They may become engaged in ongoing, destructive interactions, in which the medical or mental health or social service system replicates the behavior of the abusive family (Herman, 2009).

SAFETY ISSUES: COMPLEX TRAUMA

Herman (1997) identifies several safety concerns that providers should be aware of when working with survivors of complex trauma:

- A tendency to dissociate may make it difficult to form conscious and accurate assessments of danger.
- Survivors often have great difficulty protecting themselves in the context of intimate relationships because of difficulty establishing safe and appropriate boundaries with others. A tendency to denigrate themselves and to idealize those to whom they become attached may further cloud their judgment.
- Unconscious habits of obedience established during years of abuse can make survivors vulnerable to anyone in a position of power and authority.
- An empathic attachment to the wishes of others and an automatic, often unconscious wish to relive the dangerous situation and make it come out right may lead the survivor into reenactments of the abuse. The risk of rape, sexual harassment or battering, though high for all women, is approximately doubled for survivors of childhood sexual abuse.
- Survivors of complex trauma often feel unsafe in their bodies. Their emotions and their thinking may feel out of control, and they may also feel unsafe in relation to other people in general. A survivor shares:

“I do have an eating disorder and I’m not in control of myself when I eat. Definitely my coping mechanism has been food and then my physical body looks as unhealthy as my emotional body.”

Creating a safe environment may require survivors to make major changes in their lives, and may entail difficult choices and sacrifices. Herman (1997) elaborates:

“Without freedom, there can be no safety and no recovery, but freedom is often achieved at great cost. In order to gain their freedom, survivors may have to give up almost everything else. Battered women may lose their homes, their friends and their livelihood. Survivors of childhood abuse may lose their families. Political refugees may lose their homes and their homelands. Rarely are the dimensions of this sacrifice fully recognized.”

- Individuals with a history of chronic, long-lasting trauma are frequently misdiagnosed in the mental health system, and often accumulate many different diagnoses before the underlying problem of a complex trauma syndrome is recognized. Three particularly

troublesome diagnoses, according to Herman, have often been applied to survivors – somatization disorder, borderline personality disorder, and multiple personality disorder:

“Patients, usually women, who receive these diagnoses evoke unusually intense reactions in caregivers. Their credibility is often suspect. They are frequently accused of manipulation or malingering. They are often the subject of furious and partisan controversy. Sometimes they are frankly hated” (Herman, 2009).

- Because of encouragement by perpetrators and others to blame themselves for ongoing and repeated abuse, complex trauma victims may not seek help in situations where others would do so. A survivor shares:

“I remember my father being very violent. He would come home and have two days off from work. He was like a bear in a cage. The more he would drink, the more rage would come out, and then he would get out the belt. That was just kind of his normal routine. I think because he never taught me the importance of love and affection and respect for my mom and respect for myself, when I was sexually assaulted in high school, I was so ashamed of it and I was so fearful of him knowing that this happened, that I kept it to myself. He had trained me that when you misbehave the punishment is violence, so when I was assaulted I automatically assumed it was due to my bad behavior. It kept me from seeking help, and reporting it, and feeling like a crime happened. I felt like I had gotten into trouble and I needed to hide it the best that I could for as long as I could. Telling only meant more danger.”

- Victims of violence who are coping with several issues simultaneously may also feel immobilized due to the complexity of their situation. A survivor shares:

“My PTSD response was to become immobilized. The freezing thing – a couple of times I might have asked for help, had I not had the PTSD-conditioned response. To this day, there are still some times that, let something come at me sideways that’s unexpected, and I can go into a downward spiral. And then I think, ‘Oh my gosh, I don’t know what to do.’ So I can’t do anything.”

Empowering people with complex trauma

Here are some ways suggested by mental health professionals to empower people who are survivors of complex trauma:

- Educate survivors about trauma. Information about trauma and its impact may help individuals understand their reactions and develop increased self-compassion (Courtois, Ford & Cloitre, 2009).
- Allow individuals to be in charge their own recovery. No intervention that takes power away from traumatized people can foster their recovery, no matter how much it appears to be in their immediate best interest (Herman, 2009). The goal of advocates or other

providers is to be allies of the people they serve, placing all the resources of their knowledge, skill and experience at the disposal of the people who seek their help.

- Resist the urge to rescue. In their desire to be helpful, some advocates and other professionals may get in the habit of assuming too much personal responsibility for the people they serve and doing everything *for* them, rather than assisting people in doing

A survivor of multi-abuse trauma shares her experience with dissociation:

“My first memory of sexual abuse was when I was three, when my father raped me. At the point that I felt overpowered by him, I panicked, and my mind automatically and instinctively separated itself from my body. I dissociated. I went up to the ceiling. I went as far away as I could from what was going on and watched, as if it was happening to someone else.”

things for themselves. This may inadvertently send a message that we don’t believe people are capable of acting on their own behalf, and may feel patronizing and disempowering (Herman, 2009). “We need to be empowering, not overbearing, not handing things to them, but have them do things independently,” says Daisy Barrera (2009), an advocate from Bethel, AK. A survivor shares:

“It took independence for me to be a very strong woman, to have that strength. I’m a firm believer: Somewhere, somehow inside, every person has strength. I’m here because of my strength, because of what I was willing to take a look at, what I was willing to do. It just boils down to individuality. Not dependency, but individuality.”

- Practice humility. When we are wrong, we should promptly admit it. A sign of true competence is the willingness to acknowledge errors, blunders, and imperfections. Individuals who have survived interpersonal trauma are often not accustomed to relationships with people who admit errors and foibles, which makes repairing mistakes on the part of helping professionals both difficult and incredibly helpful (Kinsler, Courtois & Frankel, 2009).
- Avoid judgmental attitudes. People do not choose to develop complex trauma issues. Assume the attitude that people who seek your help are doing the best they can and want what is best for themselves and their families. Karen Foley, a Seattle-based behavioral health specialist, says, “I think it would be abnormal not to have the ability to function affected when somebody’s been through trauma” (Foley, 2010).
- “Normalize” responses to traumatic situations. Consider how certain behaviors and beliefs make sense or could be a reasonable response to prolonged or repeated trauma. Don’t ask, “Why is this person acting this way?” Instead ask, “What happened to this person to trigger this response?” Herman (2009) explains the need to look at behaviors

through the experience and resulting logic of the person who has survived trauma:

“The ‘characterological’ features of complex PTSD start to make sense if one imagines how a child might develop within a relational matrix in which the strong do as they please, the weak submit, caretakers seem willfully blind, and there is no one to turn to for protection. What kind of ‘internal working models’ of self, other, and relationship would be likely to develop under such circumstances? This thought experiment turns out to be quite useful clinically. One begins to understand the survivor’s malignant self-loathing, the deep mistrust of others, and the template for relational reenactments that the survivor carries into adult life.”

- Be willing to discuss “taboo” topics. For example, many people don’t want to talk about it, but some sexual abuse victims feel pleasure during the assault and feel guilty about this. If someone shares this with you, affirm for them that this is a natural response. Olga Trujillo, Director of Programs at Casa de Esperanza in St. Paul, MN, says:

“Your mind is trained automatically, instinctively, to get you out of that situation in the best way possible. And that often is through pleasure. So you may feel pleasure at some point if you are sexually abused on a regular basis. Your body will do that. It is protection, and it is an automatic response for your body to feel pleasure” (Trujillo, 2009).

- Believe people who tell you about traumatic incidents. Do this, even if what they say seems to be “bizarre” or “paranoid.” A survivor shares:

“If I had to testify, I could never say that my father threatened my life. But my father threatened my life. My father killed all sorts of pets in our home, not always in front of us, but he put them in positions where we’d find them, and we’d know he was the one who killed them.”

Working with other providers

Intensive service coordination is crucial for people with complex trauma issues. Because of the cumulative nature of complex trauma, survivors are likely to have multiple issues needing attention and to have experienced difficulty accessing the right kinds of help. Keep these ideas in mind when working with other providers:

- Train mental health professionals about the dynamics of domestic violence, sexual assault and sexual abuse, and how victims may manifest the effects of these traumas.
- Refer to providers who understand complex trauma and dissociation, and emphasize trauma-informed services (Trujillo, 2009). Trauma-informed care can be defined as care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health care and other

types of services (Huckshorn, 2004). Trauma-informed care provides a new paradigm under which the basic question is transformed from “What is wrong with you?” to “What has happened to you?” (NCTIC, n.d.)

- If possible, cultivate a pool of private practice therapists who are each willing to accept one or two people on a pro bono basis for long-term therapy. Because of the complexity of their issues, people who are survivors of complex trauma often require more intensive, longer-term therapy than publicly funded agencies can provide. For some survivors, treatment may last for years, whether provided continuously or episodically (Courtois, Ford & Cloitre, 2009). One survivor shares how important such long-term support was for her:

“I would go to my therapist in the winter months and escape to seasonal summer work, I did this for five years and my therapist was supportive and understanding. This patience with me was what I needed. Without it I would not have completed my mental health therapy.”

SUBSTANCE USE DISORDERS

While most victims of interpersonal violence do not experience substance use disorders, it is important to acknowledge that many individuals receiving services from domestic violence/sexual assault programs are dealing with substance use and recovery issues, some of which may stem from trauma.

The Illinois Department of Human Services Domestic Violence/Substance Abuse Interdisciplinary Task Force adapted this definition of substance use disorders from definitions developed by the American Psychiatric Association and the American Society for Addiction Medicine (IDHS, 2000):

Substance use disorders “involve dependence on, or abuse of, alcohol or other drugs, including the over-use or non-medical use of prescription drugs. Substance abuse is a destructive pattern of use of drugs including alcohol, which leads to clinically significant (social, occupational, medical) impairment or distress. Often the substance use continues in spite of significant life problems related to that use. When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of the substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of the substance), it is likely that the person has progressed from abuse to dependence.”

The role of trauma in substance abuse

Trauma can increase an individual’s risk for substance abuse. Some people may use alcohol or drugs as an anesthetic, to relieve the pain caused by violence. If the pain continues, and the “self-medicating” continues, conditions are perfect for dependence to develop (SAMHSA, 1997). Substance abuse or dependence also makes it harder to escape a violent situation, or to heal from past abuse (IDHS, 2000).

“We see child sexual abuse and we see a whole lot of physical and mental abuse, and then victims want to cover it up with something, so they reach out for drugs and alcohol,” says Paula Lee, Shelter Coordinator at South Peninsula Haven House in Homer, AK. “And then that becomes an issue” (Lee, 2010).

Research consistently shows a strong correlation between substance abuse or dependence and interpersonal violence:

- One study of Illinois domestic violence shelters revealed as many as 42 percent of people receiving services abused alcohol or other drugs (Bennett & Lawson, 1994).
- Data from a National Institute on Drug Abuse study noted 90 percent of women in drug

treatment had experienced severe domestic violence from a partner during their lifetime (Miller, 1994).

- Approximately 74 percent of women in substance abuse treatment have experienced sexual abuse (Kubbs, 2000).
- About 70 percent of prescriptions for tranquilizers, sedatives and stimulants are written for women (Roth, 1991), and some experts believe psychotropic medication is over-prescribed for battered women (Minnesota Coalition for Battered Women, 1992).
- The Minnesota Coalition for Battered Women (1992) notes abused women may use alcohol or drugs for a variety of reasons, ranging from coercion by an abusive partner to substance dependence, cultural oppression, over-prescription of psychotropic medication or, for women recently leaving a battering relationship, a new sense of freedom.

Continuing violence or unresolved feelings about abuse make it harder to for a victim to stay away from alcohol or drugs (IDHS, 2000). An individual may use alcohol or drugs to “stuff” feelings about the abuse (SAMHSA, 1997). A survivor of multi-abuse trauma shares:

“I drank and used to numb out. It hurt so bad, and I didn’t even know where the hurt came from, and so all I wanted to do was numb out.”

When drinking and drug use stop, buried emotions often come to the surface. For many survivors, these feelings of pain, fear or shame can lead to relapse if not addressed (Simmons et. al., 1996). Another survivor shares:

“After my first black-out at 13, I never stopped drinking until I went to residential treatment at the age of 26. I knew I had been sexually assaulted by my father, my uncles and my grandfather from age 8 to 13, but my daily black-out drinking helped me to think that it didn’t affect me. My black-out drinking helped me to believe that rather than the rapes being the truth, I must be crazy. In the middle of treatment, after repeated prodding by the counselors, reality hit and I broke down ... then the counselors told me they couldn’t help me with the incest issues.”

Individuals coping with violence and their own substance abuse often find themselves caught up on a merry-go-round. Substance abuse makes it harder to escape a violent situation, or to heal from past abuse. At the same time, continuing violence or unresolved feelings about past abuse make it harder to stay away from alcohol or drugs.

Barriers to service

A significant number of interpersonal violence survivors who also have substance use disorders experience barriers to services. Barriers may include:

SAFETY ISSUES: SUBSTANCE USE DISORDERS

While substance abuse does not cause violence, it can make a violent situation more dangerous in a variety of ways:

- If the perpetrator is intoxicated, there is a greater risk a domestic violence victim will be injured or killed. Research shows the presence of violence and substance abuse together increases both severity of injuries and lethality rates (Dutton, 1992). Fatality Review panels in Washington state identified substance use as an issue in 73% of the reviewed domestic violence homicide cases over a two-year period. In those cases, 100% of the abusers and 62% of the victims had substance use disorders (WSCADV, 2006).
- Substance abuse makes it harder for a victim to get safe, for several reasons (IDHS, 2000): Substance abuse impairs judgment, which makes safety planning more difficult. The victim may avoid calling police for fear of getting arrested or being reported to a child welfare agency. And, a victim may be denied access to shelters or other services if intoxicated.
- In an abusive relationship, the victim's recovery may threaten the partner's sense of control (Foley, 2010). To regain control, the partner may try to undermine recovery in a variety of ways: pressuring the victim to use alcohol or drugs; discouraging the victim from keeping counseling appointments, completing treatment or attending meetings; or escalating the violence (SAMHSA, 1997).

Participants in a support group for people with multiple abuse issues in Seattle, WA have disclosed that batterers may try to lure them from shelter by offering drugs, sabotage recovery efforts by demanding they leave treatment against medical advice, prevent them from attending community support groups, make false or exaggerated allegations to the Office of Children's Services, terrorize them with threats of institutionalization and/or blame them for their abuse because of their substance use disorder (Bland, 2007).

- *Fear of legal sanctions.* A victim of violence who has substance abuse issues may be reluctant to contact police or seek other assistance for fear of prosecution or investigation by a child welfare agency (IDHS, 2000). Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle, says:

“People can't call the police when there's substance abuse involved, because there's paraphernalia, or there might be drugs on site. So somebody's life might be in danger and they don't feel safe to call the police” (Foley, 2010).

- *Fear of being judged.* Societal attitudes tend to view addiction as a moral failing rather than as a health problem. This can lead to isolation and shame, which may be

compounded when domestic violence and/or sexual assault co-occur. People with a substance use disorder face tremendous stigma and are often considered bad parents, bad people, bad victims and resistant to treatment.

- *Self-blame.* Victims may have been told in the past that violence or other abuse was their fault because of their alcohol or drug use. As a result, they may not recognize domestic violence or sexual assault for what it is. A survivor shares an experience that happened to her when she was in her teens:

A survivor of multi-abuse trauma shares:

“I’d call my mom drunk and say, ‘He hit me again, but I really deserved it this time.’ I can’t even imagine saying that today.”

“I hadn’t even realized a couple incidents in my life were sexual assault. It’s so clear when I think about it now. I was just blaming myself. Well, I shouldn’t have been drinking. There was this big party. The mom was drinking with the kids, and people were coming over, and there was drinking and pot. I remember being in a room and a person maybe five years older than me came in and raped me. And then

another person came in who was much older than that. I think he was maybe 10 or 15 years older than I was. So it’s interesting that I blamed myself. It seems like a lot of young girls do that.”

- *Behavior that bars an individual from services or creates challenges for staff.* Withdrawal symptoms, along with the compulsion to use, may make it difficult for victims of domestic violence/sexual assault who are substance-dependent to access services such as shelter, advocacy, or other forms of help (IDHS, 2000). Challenging behavior may include coming back to shelter intoxicated, violating curfews or failing to keep appointments.

- *Discrimination.* Ability to find or maintain employment, housing or health insurance may be threatened by disclosure of current or past substance abuse problems. This may be true even if an individual has been in recovery for several years. Even some domestic violence shelters subtly discriminate against people with substance abuse issues, says Karen Foley of Triple Play Connections in Seattle:

“How do people who are using to cope with the violence go into a shelter or transitional living program that isn’t equipped to deal with their substance abuse or addiction? A program that often kicks them out and sends them back to their abuser rather than helping them get clean and sober or access treatment?” (Foley, 2010)

- *Inability to afford appropriate services.* People may be unable to afford treatment if they do not have insurance, or have insurance that doesn’t cover services adequately (a problem for an increasing number of middle-class people as well as those living in poverty).

- *Unavailability of services.* Treatment centers in many communities have lengthy waiting lists, due in large part to reduced funding for treatment, so even those individuals who recognize the need for treatment may be delayed in getting it (Obtinario, 2010).
- *Lack of education on the part of providers about the nature of substance use disorders.* A surprising number of providers still buy into the idea that people who are dependent on alcohol or drugs really could stop using if they wanted to, or if they tried a little harder. A survivor shares:

“They’d say, ‘You just need to watch your drinking and don’t get so carried away with it.’ Well, that doesn’t work with alcoholism. I kept trying to do it right, I’m telling you! And I tried to ‘do it right’ for years.”

Sometimes individuals are caught up in a no-win cycle, in which they can’t access services at either a shelter or a treatment center. Naomi Michalsen, Executive Director of Women In Safe Homes (WISH) in Ketchikan, AK, explains:

“We say things like, ‘You probably should do some work with the substance abuse first.’ We’re trying to tell her what to do. So she goes to the treatment center and knocks on the door. They open the door and say, ‘We don’t take children.’ What does the woman do? She doesn’t get either. And we’re not helping anybody, because I believe that the majority of the women that are in these situations have a coping mechanism and are using. So that’s a barrier.”

Empowering people with substance use disorders

When someone has a substance use issue, supporting sobriety can be as empowering as supporting safety, if sobriety is the individual’s choice. Even if the person does not choose – or is unable – to stop at this time, there are many ways for an advocate to be of help. Here are some ways to empower people who have substance use disorders:

- Be willing to work with people who seek your services regardless of whether they are using or not using. When she encounters someone with substance abuse issues, “we’re going to work with that person to try to hook them up with the resources they need,” says Cindy Obtinario, a chemical dependency/domestic violence specialist with New Beginnings in Seattle, WA:

“Whether that means they go to detox, or the emergency room if they can’t get into detox, whether that means they get involved in inpatient or outpatient treatment, whether that means they get in for an assessment right away or perhaps get no formal treatment. We will work with the person that has the alcohol or drug issue based on where they are” (Obtinario, 2010).

- Help people find alternate ways to feel powerful. Assist people in finding an alternate means of empowerment as replacement for the sense of power induced by substances. Validate that anyone facing interpersonal violence might use drinking or drugging to

cope but there are safer ways to survive domestic violence, rape trauma and abuse, as well as homophobia, racism, ageism, ableism, classism and other forms of pain and oppression (Bland, 2008).

- Encourage appropriate use of support groups. Because people impacted by substance use, misuse or addiction may be at greater risk for injury and lethality, support groups addressing substance use as a safety issue are often essential for individuals impacted by domestic violence and sexual assault. If 12 Step groups are used to support recovery, help the individual find ways to interpret 12-Step concepts that are appropriate for survivors of abuse, or find a sponsor who has an appropriate understanding of the dynamics of domestic violence (Obtinario, 2010). Encourage women to attend all-women’s meetings if they find mixed-gender groups intimidating. A survivor shares:

A survivor of multi-abuse trauma shares:

“I drank and used to numb out. It hurt so bad, and I didn’t even know where the hurt came from, and so all I wanted to do was numb out.”

“The Fourth Step of taking a personal inventory while working the 12-Step program can be a problem. Many survivors of abuse feel they have to take responsibility for the abuser’s actions but a knowledgeable sponsor working an honest program will redirect them like my sponsor did for me. For me taking inventory meant looking at the truth of my fears and resentments while understanding there were times in my life when people did hurtfully horrendous

things to me through no fault of my own ... and forgiveness is to cease to have ‘a resentment against.’ It is not an invitation to, nor an excuse for, the abuser. I forgave my father to get the rage out of my spirit but I would never trust him again with myself, or ever with my children.”

Another survivor shares: “You don’t make amends to a dealer and you don’t make amends to a batterer, a rapist or an abuser.”

- Be aware of alternative support groups. Be aware of and refer to alternative support groups such as Women for Sobriety or Wellbriety groups or Talking Circles for Native Alaskans and American Indians where these groups are available.
- Be aware of the singleness of purpose in 12-Step and some other support groups. Chemical dependency counselor and ANDVSA statewide training team member, Tia Holley says, “Some group members may react negatively to full disclosure. I tell people in the program that everything that affects their life affects their recovery.” Experiencing domestic violence and sexual assault can lead to relapse. Seeking safety can also be a factor in relapse. Advocates and other providers should encourage the development of local resources and support groups where it is safe for participants to talk about recovery in the context of domestic violence, sexual assault and child sexual abuse (Holley, 2011).

- Stress that substance use or abuse does not justify violence. Victims of sexual assault or domestic violence often blame themselves for the violence they have suffered, and this is especially true if they have been using alcohol or drugs. Victims often believe they are being abused because of their substance use and people around them often believe this as well (IDHS, 2000). A survivor shares:

“I’d call my mom drunk and say, ‘He hit me again, but I really deserved it this time.’ I can’t even imagine saying that today.”

- If a person is in recovery from a substance use disorder, include relapse prevention in safety plans. When people are harmed, they may be more likely to use substances to cope. They may use alcohol or drugs to medicate physical and/or emotional pain. They may even be coerced into use by a partner — the abuser will often do whatever it takes to keep the victim under control, including forcing use of substances. Include plans for continued sobriety as part of safety planning, and help the individual understand ways an abuser may attempt to undermine sobriety (IDHS, 2000).

- If a person is not ready to stop using, discuss ways to reduce risk. Discuss alcohol or drug use as a safety issue and explore options (Obtinario, 2010). Are there ways to cut back on drinking or using? Can the individual find a safe environment and be with safe people before using? “I always connect alcohol or drug use to safety,” says Cindy Obtinario of New Beginnings in Seattle. “We always talk about that as part of a safety plan. It’s standard.”

- Avoid being judgmental, even if you are unable to continue services at this particular time. Cindy Obtinario says:

“When someone chooses not to be sober, it’s still important to let her know that we’re concerned for her and talk about safety. And then talk about harm reduction. Let her know that while our guidelines about use and participation in group require non-use that day, she’s welcome to come back. We have no animosity toward her because she’s made a choice to use and to leave” (Obtinario, 2010).

Working with other providers

When coordinating services with substance abuse treatment providers:

- Develop relationships with individual treatment providers. Cindy Obtinario of New Beginnings has worked for several years to develop relationships with substance abuse counselors. She says:

“They’ve been pretty good. Because we’ve had that conversation, I can call and say, ‘We’ve got this woman here, she’s in a dangerous situation, and we are attempting to get her an assessment so that we can best refer her to get the treatment needs she has met, in order to also keep her safe’” (Obtinario, 2010).

- Be aware of which providers and community support groups provide the highest degree of physical and psychological safety for people who have interpersonal violence issues.
- Educate treatment providers about the safety needs of people coping with interpersonal violence. For example, emphasize that couples counseling can be very dangerous for domestic violence victims (IDHS, 2000). Also be aware of possible danger if a personal care attendant or caregiver is involved in counseling sessions with a victim who has disabilities (Leal-Covey, 2011).
- Confrontational techniques are often not effective with victims of interpersonal violence and can be interpreted by survivors as an extension of how an abuser treats them (IDHS, 2000). Seek out treatment providers who use motivational interviewing, solution based therapy or other empowering approaches that are more appropriate for survivors of violence or abuse.

MENTAL HEALTH CONCERNS

The National Alliance on Mental Illness defines *mental illness* as a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Examples of mental health conditions include depression, anxiety, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder and post traumatic stress disorder (NAMI, 2009).

Warshaw (2010) defines a *mental health issue* as a situation or concern involving alterations in thinking, feelings and/or behavior, associated with emotional distress and/or difficulties in functioning that the individual and/or others want to resolve. A mental health issue becomes a *psychiatric disability* when the effects of trauma and/or mental illness significantly interfere with the performance of major life activities. Psychiatric disabilities may come and go, remit, or become more persistent.

About one in four adults experiences a mental health condition in a given year, according to the National Institute of Mental Health. One in 17 lives with a serious psychiatric disability, such as schizophrenia, major depression or bipolar disorder (NAMI, 2007).

The role of trauma in mental illness

While not all mental illnesses are caused by traumatic experiences, trauma may cause or exacerbate some mental health conditions.

Individuals living with chronic mental illness experience higher rates of abuse, while those abused in childhood experience higher rates of psychiatric symptoms as adults (Warshaw, 2010). Many behaviors and responses seen as "symptoms" by advocates and other providers are directly related to traumatic experiences that cause mental health concerns (NCTIC, n.d.):

- Depression, post-traumatic stress disorder, anxiety and panic disorder are common among people in domestic violence shelters (Warshaw et. al., 2003).
- Individuals experiencing any type of domestic violence are nearly three times more likely to report symptoms of severe depression (Warshaw, 2010).
- As many as 90 percent of people who have severe psychiatric disorders are survivors of at least one incident of trauma during their lifetimes (Akers et. al., 2007).
- Studies have found that up to 53 percent of people who seek services from public mental health centers report childhood sexual or physical abuse (Huckshorn, 2004).

- In one study, 90 percent of women hospitalized post-suicide attempt reported current severe domestic violence (Warshaw, 2010).
- In another study, 90 percent of people with mental health issues had been exposed to trauma, and most had multiple experiences of trauma (Huckshorn, 2004).

When trauma survivors develop psychiatric problems, systems of care often perpetuate traumatic experiences through invasive, coercive or forced treatment that causes or exacerbates feelings of threat, a lack of safety, violation, shame and powerlessness (NCTIC, n.d.).

Barriers to service

According to the U.S. Department of Health and Human Services, fewer than one-third of adults with a diagnosable psychiatric disorder receive any mental health services in a given year. Racial and ethnic minorities are even less likely to have access to mental health services and often receive a poorer quality of care (NAMI, 2007). People with mental health issues may encounter a number of barriers when seeking help:

- *Stigma.* The single most pervasive factor affecting access to and participation in services is the stigma accompanying mental health issues. Individuals with psychiatric symptoms often encounter people who avoid or shun them because of myths about mental illness.
- *Trust issues.* People may be reluctant to share mental health concerns with advocates or other providers for fear of being discounted. Others may have suggested they have a distorted view of reality, especially if they bring up problems or issues that make others uncomfortable. Abusive partners or parents may encourage people with mental health issues not to trust their own judgment or perceptions, and providers may sometimes do this as well.
- *Reliance on imported mental health providers to rural or underserved areas.* People may also be reluctant to trust itinerant service providers who may not remain long enough to provide continued services. This can lead to fractured therapy. Trust barriers are compounded if such providers do not understand local customs, diversity issues, intergenerational trauma or history of disparity of treatment to marginalized victims (Holley, 2011).
- *Fear of losing autonomy.* Providers in the past may have suggested that people with mental health conditions are incompetent to make their own decisions, or lack the insight to know what they need. Such providers may have used this perception as a reason to impose their own solutions, push medications or force hospitalization. A survivor shares:

“I went to therapy several times, and I went to doctors and emergency rooms, and they all put me on pills. I had a hard time with that. Most of the therapists I’ve seen,

SAFETY ISSUES: MENTAL HEALTH CONCERNS

For individuals experiencing interpersonal violence, psychiatric symptoms can have an impact on safety:

- Accurate assessment of danger may be impacted by thought disorder symptoms (Bland, 2007). Traumatic brain injury or mental health symptoms can impair judgment and thought processes (including memory), making safety planning more difficult. People with psychiatric symptoms may be reluctant to seek assistance, because they fear being labeled, institutionalized or medicated.
- Mental and physical problems, whether temporary or more long-term, can diminish some people's ability to work, participate in job training or education programs, or comply with government benefit requirements (Davies, n.d.). All of these factors can make it harder to escape violence.
- Trauma symptoms can mimic mental illness, and trauma survivors may be misdiagnosed when the traumatic effects of abuse aren't taken into account (Warshaw, 2010). Examples include survival strategies seen as disorders ("over-reaction" to minor stimuli versus acute social awareness) and "symptoms" that are actually an appropriate response to ongoing danger or victimization. This could lead providers to focus too much on obvious psychiatric symptoms and fail to see the danger posed by the individual's situation. Shirley Moses, Shelter Manager at the Alaska Native Women's Coalition in Fairbanks, AK, says:

"They can see that the person is distraught, and not able to function on a daily basis, but they don't recognize the things that are going on. They look at what *they* think might be wrong and they *assume* there are mental health issues. It might just be a situation where the person had a breakdown. They've finally had enough and they show symptoms of mental illnesses, but it's situational. They are trying to deal with domestic violence or sexual assault and they are overwhelmed. They are at a loss as to what they can do" (Moses, 2010).

- Abusers use mental health issues to discount their victims or control them. Behavioral health specialist Karen Foley says:

"I have someone who is unable to take her medication because her partner can control her better when she's not medicated. There are also a lot of people I work with who make appointments for therapy and are not able to follow through with those appointments. Some of that, I think, stems from the fear of letting out those family secrets. Other people barge in on their family member's mental health therapy appointments and call it family therapy, and the individuals end up in a very dangerous position if they reveal anything. At best they keep quiet and no real therapy happens" (Foley, 2010).

you can't see them without seeing the pill doctor first. Some people do need meds. But I felt like I got used and abused by the pharmacy as a guinea pig. Is this going to work? Is that going to work?"

- *Fear of losing children.* Parents may fear they will be judged too incompetent, violent or even dangerous to provide adequate parenting because of psychiatric issues (Nicholson et. al., 2001). Fear of losing custody can keep a parent from acknowledging mental health problems and requesting services.
- *Too much focus on deficits rather than strengths.* Services tend to be deficit-based, often available only when people with mental health concerns have diagnosable symptoms or when abuse or neglect of their children has been documented. A focus on deficits and the assumed inadequacies of people with psychiatric issues, rather than their strengths, contributes to a cycle of hopelessness and a view of the “helping” relationship as adversarial (Nicholson et. al., 2001).
- *Lack of affordable services.* People with mental health concerns may be unable to afford services if they do not have insurance or have an insurance policy that doesn't adequately cover mental health services. This can be a problem for people with middle-class incomes as well as people who live in poverty. Managed care policies may try to limit the type or amount of services that are covered by insurance.
- *Behavior that poses challenges for staff.* A person with psychiatric issues such as complex trauma, bipolar disorder or schizophrenia may behave in ways that are perceived as disruptive, particularly in a shelter or a residential facility.

Empowering people with mental health issues

Most of the primary skills advocates use with people affected by mental health issues are no different from those used with any other survivor. But there are specific things to know about the needs, reactions, symptoms and experiences of survivors who have a psychiatric disability. Pease (2010) lists some common experiences of persons with mental illness:

- *Difficulty with thinking and processing.* Anxiety, depression, medication, disturbing thoughts or cognitive difficulties may interfere with concentration.
- *Difficulty managing feelings or interaction with others.* The survivor may have strong reactions to “minor” irritants, may react to small criticisms or suggestions in ways that seem extreme, or may disengage, not addressing conflicts or problems.
- *Difficulty screening out stimuli.* Both external and internal stimuli may be distracting and disorganizing to the person you are working with.
- *Low stamina.* The person may “run out of steam” in meetings or sessions, withdraw

from activities, give little attention to the children, or be unable to complete tasks and chores.

Safety and support can reduce psychiatric disability for trauma survivors (Warshaw, 2010). Here are some ways to empower people with mental health concerns:

- Respond to people, not diagnoses. When looking at a trauma survivor’s symptoms and behaviors, ask: How do these things make sense? How do they help? How can we help this person make the changes they want? What would this person need in order to cope without these symptoms? (Pease, 2010).

- Recognize that domestic violence, trauma and psychiatric disability are linked, and the pain of trauma and violence can be disabling for some survivors. Responding to that pain need not disempower survivors nor disregard their strength – we should not require survivors to resolve the pain of their experiences on their own before we offer them support and advocacy for the violence or abuse they have experienced (Pease, 2010).

A survivor of multi-abuse trauma discusses what she feels was pressure to use medications:

“I went to therapy several times, and I went to doctors and emergency rooms, and they all put me on pills. I had a hard time with that. Most of the therapists I’ve seen, you can’t see them without seeing the pill doctor first. But I felt like I got used and abused by the pharmacy as a guinea pig. Is this going to work? Is that going to work?”

- Don’t make people feel guilty or wrong for coming to you for help. If lack of appropriate training or credentials prevents you from answering a question (about medications, for example) or providing a certain kind of assistance, explain this. Make an appropriate referral and emphasize that people are not wrong for coming to you with this particular problem. Make it clear that you will help them figure out who can provide the needed help and are happy to explore options.

- Set respectful boundaries. If someone seems to engage in “attention seeking behavior” by making repeated demands on your time, explain that you have a conflict that prevents you from talking at the moment. But assure the individual that you will give them your undivided attention if they come back at a designated time.

- Believe people who tell you about traumatic incidents, even if they seem confused or out of touch with reality, or say something you perceive to be inaccurate. Try asking yourself, “What might be happening to make this seem true for this individual?” Consider how some behaviors and beliefs make sense or could be a reasonable response to multi-abuse trauma. Don’t ask, “Why are they acting this way? Instead ask, “What happened to

them to trigger this response? How can I help them find safer ways of coping that cause less grief?” Abusers often manipulate their victims to doubt their own perceptions by convincing them that they are “crazy” (Foley, 2010).

- Clarify the appropriate role of 12-Step groups for people who use them. Some people report that their sponsor or 12-Step group has tried to discourage their use of medications to treat mental illness. Providers should point out that Alcoholics Anonymous itself takes no official stance on the use of prescription medications. Also point out that 12 Step

groups are not meant to be a substitute for therapy. Tia M. Holley reports:

A survivor of multi-abuse trauma shares:

“I was poor, because I was jobless. I was homeless, and I had a mental health diagnosis. So how I was treated, in retrospect ... because I had a bus pass for people with disabilities – I was not treated very well by many different groups in society. I look back on that and I remember I would feel so ashamed because I had to use the bus pass. And sometimes the way people would look at me – because on the outside, I was physically able to move around, nobody knew what was going on behind the scenes, what was going on with me.”

“As a substance abuse counselor here in Alaska, I have seen people in recovery feel pressured to be 100 percent substance free, quit taking needed psych meds and then go on to commit suicide. This pressure can come from peers in recovery groups, or from family who believe that the substance use was creating the mental illness” (Holley, 2011).

- Pay attention to accessibility issues (Warshaw & Pease, 2010c). Mental illness is covered under the Americans with Disabilities Act, and reasonable accommodations should be made where needed. Examples of accommodations include allowing a longer time to achieve certain goals or complete tasks, part-time rather than full-time work, extra privacy, and attention to sensory issues.

- Examine medication policies to ensure survivor autonomy and control. While some survivors welcome medication to manage

symptoms and improve their ability to function, others may have legitimate reasons for not wanting to take medication. Concerns may include fear of side effects, worries about long-term effects, or distrust of current research on medication safety (Pease, 2010). Pease points out that if we refer for medication to change a survivor’s behavior, help a survivor “fit in” to a program or make other staff/residents more comfortable, we are exercising power and control. Ideally, each individual should have access to their own locked medicine cabinet in their own room.

- Be aware of the ways an abuser can use mental health issues against a victim (Pease, 2010). Perpetrators often convey the message that their victims deserved abuse because they were “acting crazy.” Make it clear to people who have been victimized (and to other providers) that nobody deserves violence or abuse, no matter what else is going on.
- Also be aware of the ways batterers use mental health issues to control their partners – for example, control of medications, coerced overdose, control of treatment, undermining credibility and attacking parenting skills. Warshaw (2010) points out that this works because of the stigma society attaches to mental illness.
- Safety planning should address mental health-specific issues – i.e., medication, control of treatment decisions, and what to do if symptoms keep individuals from being able to advocate for themselves – as well as general safety issues (Pease, 2010).
- Affirm autonomy and the right to control decision-making. Affirming people’s right to make their own choices that are right for them is especially important in light of the fact that an abuser (or even other providers) may have implied they lacked the insight or capability to make their own decisions.
- If psychiatric hospitalization becomes necessary, determine what supports you can offer such as calls, visits and continued services. With permission, and if a release of information has been signed, discuss safety concerns with hospital staff such as allowing the person to refuse calls or visits from the abuser, and safety planning on discharge (Pease, 2010).

Working with other providers

When working with mental health providers:

- Refer to providers that incorporate trauma-informed care into their services. Trauma-informed care is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services (Huckshorn, 2004).
- The Wellness Recovery Action Plan™ (WRAP) used by many mental health professionals lends itself well to safety planning for domestic violence issues as well as mental health issues. WRAP is a structured system for monitoring symptoms through “Advance Directives” – i.e., “If I cannot advocate for myself, please do this ... and not this. Involve this person ... and not this one.” Advance Directives can afford protection if they keep an abuser from being involved in treatment decisions (Pease, 2010).
- Training for mental health providers should include the dynamics of domestic violence/sexual assault, the importance of not blaming victims, tactics abusers may use to control or interfere with treatment, the importance of not overemphasizing the role of

medication, and the dangers of couples counseling under the family systems model when one partner is an abuser (Warshaw, 2010).

- If possible, cultivate a pool of private practice therapists willing to accept one or two people or families on a pro bono basis. This can be particularly helpful for individuals who need family therapy for themselves and their children in communities where public mental health centers separate adults and children into separate programs because of funding constraints.

DISABILITIES/DIFFERING ABILITIES

Under the Americans With Disabilities Act, an individual is considered to have a "disability" if she or he has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. Examples offered by ADA of major life activities include seeing, hearing, speaking, walking, breathing, performing manual tasks, learning, caring for oneself, and working (US EEOC, 2002). Disabilities that fall under this definition range widely, from sensory or physical (such as conditions impacting vision or hearing or mobility) to psychiatric (such as depression or schizophrenia), cognitive (such as Alzheimer's or dementia) and developmental (such as Down Syndrome, autism or fetal alcohol spectrum disorder).

In contrast to the *medical model* of disability, which focuses on individual "deficits," is the *social model* of disability. The social model of disability identifies systemic barriers – inaccessible buildings, negative attitudes that result in prejudice and discrimination, and inadequate support – as the main factors in disabling people. Proponents of the social model argue that while physical, sensory, intellectual, or psychological variations may cause individual functional limitation or impairments, these do not have to lead to disability unless society fails to accommodate and include people regardless of their individual differences (ASI, 2010).

The term *neurodiversity*, stemming from the social model of disability, was coined by autism activist Judy Singer and refers to a number of conditions resulting from neurological differences such as attention deficit hyperactivity disorder, dyslexia, intellectual impairments, autism, schizophrenia and mood disorders (Armstrong, 2010). The emphasis in neurodiversity is placed on accommodating and accepting differences, and people are encouraged to focus on strengths associated with these conditions rather than focusing solely on "deficits" (Armstrong, 2010).

The role of trauma in disabilities

People with disabilities are at an extremely high risk for emotional, sexual and physical violence or abuse (Wayne State University, 2002).

- A person with a disability – regardless of age, socioeconomic status, race, ethnicity or sexual orientation – is twice as likely to be a victim of abuse than a person without a disability (Wayne State University, 2002).
- In addition to abuse by family members or intimate partners, people with disabilities are at risk for abuse by attendants or care providers. They are also more likely to experience a longer duration of abuse than people without disabilities (Young et. al, 1997).

- Street crime is a more serious problem as well. Studies have shown that people with disabilities have a four to ten times higher risk of becoming crime victims than persons without disabilities (Wayne State University, 2002).
- Emotional, physical, and sexual abuse of people with disabilities is a problem largely unrecognized by rehabilitation service providers (Young et. al, 1997).

Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle, says:

“I have someone right now who has a developmental disability, and her partner takes her Social Security money. That keeps her financially bound, unable to move, unable to get safe” (Foley, 2010).

Barriers to service

For people in abusive situations, crisis intervention may include escaping temporarily to a shelter, escaping permanently from the abuser, and having an escape plan ready in the event of imminent violence if the person must remain with the perpetrator. However, these options that many people take for granted may be problematic for people with disabilities. Here are some common barriers to accessing services:

- *Lack of accessibility.* According to the National Coalition Against Domestic Violence and the National Coalition Against Sexual Assault, inaccessibility in shelters and other advocacy services is a serious problem. These programs generally operate on very thin budgets and covering the cost of accessibility modifications and services is a substantial challenge. One study found that only about a third of providers offered safety plan information modified for use by people with disabilities, or disability awareness training for program staff, and personal care attendant services were available in only six percent of programs (Nosek et. al, 1997).
- *Lack of supportive services.* Even if the shelter itself is physically accessible, there may still be accessibility issues if the shelter is unable to meet an individual’s needs for personal assistance with activities of daily living, if there is no accessible transportation to the facility, or if the shelter staff are unable to communicate with a person who has a hearing or speech impairment (Nosek et. al, 1997).
- *Trust issues.* People with disabilities may be reluctant to disclose abuse because of worry that their disability will be used to discount their perceptions or take away their autonomous decision-making power. They may fear being judged incompetent to care for themselves or live independently. Parents may fear that they will be judged too incompetent to provide adequate parenting because of disability issues. They may have been accused of malingering in order to get benefits, or told they could do certain things if they really wanted to.
- *Too much focus on deficits rather than strengths.* A focus on deficits and the assumed

SAFETY ISSUES: DISABILITIES

People with disabilities may face special safety risks when seeking to escape violence:

- People with disabilities may not be able to physically fight back or walk away from a potentially harmful situation (Wayne State University, 2002).
- Many people with disabilities depend on caregivers – either a spouse, other family members, or paid assistants – for essential personal services. This dependence can create a barrier to terminating an abusive situation because to do so would leave the victim without essential support services (Wayne State University, 2002).
- The individual may be physically incapable of executing the tasks necessary to implement an escape plan, such as packing necessities and driving or arranging transportation to a shelter or a friend’s home (Nosek et. al, 1997).
- If a person has a developmental disability, cognitive and processing delays may interfere with the ability to understand what is happening in abusive situations. This problem is compounded by the fact that people with developmental disabilities are often not provided with general sex education, so they may not recognize what is happening to them in a sexually abusive situation (Charlton & Tallant, 2003).
- Many adults with disabilities have had a lifetime of negative encounters with social service and criminal justice systems. As a result of prior ineffective remedies and harmful consequences, survivors may be hesitant to use systems and resources as part of safety planning (Hoog, 2010).
- Survivors may fear being institutionalized or suffering other loss of autonomy if they disclose abuse (Hoog, 2010).
- Abusers may use disability issues to control a victim, by withholding caregiver services or money, or threatening to do so (Leal-Covey, 2011).

inadequacies of people with disabilities, rather than on their strengths, may contribute to a cycle of hopelessness and a view of the “helping” relationship as adversarial (Leal-Covey, 2011).

- *Lack of affordable services.* People with disabilities may be unable to afford services if they do not have insurance or have an insurance policy that doesn’t adequately cover services or equipment (Leal-Covey, 2011). This can be a problem for people with

middle-class incomes as well as for people who live in poverty. Managed care policies may try to limit the type or amount of services that are covered by insurance.

- *Difficulty following procedures.* A person with disabilities may have trouble completing tasks or following certain rules. Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle, says:

“One person I’m working with was in a homeless shelter, and her developmental disabilities were interfering with her ability to follow through with her service plan. And if she doesn’t follow through with her service plan, it affects everything. So she has been kicked out of the homeless shelter because she can’t follow her service plan. Her money from DSHS (Department of Social and Human Services) – that money has been sanctioned because she has been unable to follow through on her service plan” (Foley, 2010).

Empowering People with Disabilities

Following are some ways for advocates and counselors to empower people with disabilities:

- **Work to improve accessibility.** Ensure that all services are accessible and integrated for people with disabilities, including hot lines, individual counseling and support groups. Modify shelters so they are fully accessible, including barrier-free access to sleeping rooms and common areas, architectural features that comply with the Americans with Disabilities Act, visual and auditory alarm systems and available interpreters (Nosek et. al, 1997).

- **Avoid making assumptions about the needs of people with disability issues.** Cecilia Leal-Covey, an advocate and consultant in Reno, NV, says:

“In Nevada, a shelter told a victim in a wheelchair to find other services because the shelter was not accessible for her. The ‘advocate’ saw the wheelchair, thought the woman needed caregiving, and denied services. The shelter was accessible for the victim and the victim did not need caregiving. The advocate made an assumption, and the victim was left on the street without options” (Leal-Covey, 2011).

- **Modify safety plans as needed.** Examples of modifications may include a medical alert device which can be worn at all times without suspicion and used to call for help; keeping an extra set of medical supplies or adaptive equipment at a friend’s or relative’s place; or setting up an alternative caregiver or personal assistance if needed (Hanson, 2000).

- **Help individuals understand their legal rights.** People with disabilities who depend on caregivers, either at home or in institutions, may need special legal protection against abuse (Nosek et. al, 1997).

- **Ask about needs.** While asking a question such as “Do you have special needs we should be aware of?” may feel disempowering, a general question would be appropriate

to ask anyone seeking services, whether they have a disability or not. Examples of general questions would include: “Would you let me know if you need anything?” Or, “Please feel comfortable asking if you need anything.”

- Provide extra advocacy, if needed and requested. A survivor shares:

“I was lucky I had some people that helped advocate for me and helped me advocate for myself. There were some things I needed to challenge, and I ended up having to go up the ladder two layers of management to deal with one particular situation, which was keeping my animal as a service animal. I would not have had the emotional strength for the fight, because one of my responses with PTSD was to pull back and shut down, had I not had someone helping me advocate for myself and supporting me through that process.”

- Recognize that some disabilities are invisible, but pose legitimate challenges nonetheless. A survivor shares:

“I was poor, because I was jobless. I was homeless, and I had a mental health diagnosis. So how I was treated, in retrospect, by housing authority people, some mental health folks, the metro transit people, because I had a bus pass for people with disabilities – I was not treated very well by many different groups in society. I look back on that and I remember I would feel so ashamed because I had to use the bus pass. And sometimes the way people would look at me – because on the outside, I was physically able to move around, nobody knew what was going on behind the scenes, what was going on with me.”

Working with other providers

When collaborating with agencies or programs that serve people with disabilities:

- Advocates should collaborate with personal care attendant agencies and independent living centers to enable the provision of personal assistance services for people with severe disabilities at emergency shelters. Have on hand an extensive network of community referrals and contact numbers, including volunteers or other community resources for obtaining personal assistance (Nosek et. al, 1997).
- Don’t be afraid to ask for help. Disability-related service providers are usually eager to offer their assistance to other community providers with questions about how to make their services more accessible. Accessibility is not necessarily an expensive proposition. Sometimes improving accessibility may be as simple as relaxing a policy or rule, or giving someone more time to complete a task or goal (King, 2009).
- Provide cross-training. Train advocates on how to communicate with persons who have hearing, cognitive, speech, or psychiatric disabilities. Staff should understand environmental barriers faced by people with physical and sensory disabilities when offering advice or referrals for obtaining shelter. Also offer training to disability-related service providers, including independent living centers and personal care attendant

agencies, on recognizing the symptoms of abuse and the characteristics of potential perpetrators. These service providers should be familiar with and able to refer to resources for victims of violence or abuse in their community (Nosek et. al, 1997).

- Train law enforcement officers about the special needs of victims with disabilities. The sensitive handling of domestic violence and sexual assault against people with disabilities should be a mandatory part of the training of law enforcement personnel in every city. They need to be aware of the additional measures that may be needed to keep a victim with a disability safe from the perpetrator (Nosek, et. al, 1997).
- When making referrals, be aware of which providers and community support groups provide the best accessibility for people with disabilities (Leal-Covey, 2011).

SOCIETAL ABUSE AND OPPRESSION

Societal abuse is a form of *active abuse* that refers to the disadvantages an individual or group experiences as a result of unjust social structures (Benbow, 2009). Societal abuse is a root cause of most other types of abuse – including domestic violence and sexual assault – and covers a wide range of issues (WHO/INPEA, 2002). Examples of societal abuse include sexism, racism, heterosexism and other forms of oppression that grant variable human worth to individuals based on misconceptions about race or ethnic culture, gender, sexual orientation, age, disability, socioeconomic background, recent immigration, military or other status.

Manifestations of societal abuse may range from overt or covert discrimination and lack of accommodations to inadequate funding for social services, lack of access to health care, inadequate social policies to protect against abuses, and negative images and stereotypes in the media (Schwartz-Kenney et. al, 2001). On both the individual and group level, societal abuse also tends to include the denial of victims’ pain and suffering, as well as blaming victims for abuses committed against them.

Societal abuse is perpetuated by society through its dominant culture and values, or by its tendency to accept abusive behavior toward marginalized groups (Schwartz-Kenney et. al, 2001). At its most extreme, societal abuse can take the form of human trafficking, forced dislocation and genocide. The trauma resulting from the societal abuse of oppressed groups can be passed from one generation to the next in the form of *intergenerational grief* and *historical trauma*.

The role of trauma in societal abuse/oppression

Cultural oppression and other forms of societal abuse are traumatic to the people who are targeted and can, in themselves, result in stress symptoms. Some experts speak of *minority stress* (Green, 2007) and *postcolonization stress disorder* (Comas-Diaz, 2007), which result from struggling with social oppression and marginalization, as well as the imposition of “mainstream” culture as dominant and superior. Psychological effects may include depression, anxiety, shame or rage, and post-traumatic stress disorder.

Marginalized groups tend to be disproportionately affected by poverty, homelessness and incarceration – not because they commit more crimes or have greater rates of pathology, but because discrimination often keeps them from getting the same benefits enjoyed by members of the dominant culture. For example:

- The U.S. Census Bureau reports that about 31.1 million people were poor in the year 2000, a poverty rate of 11.3 percent. However, the poverty rate for African-Americans, 22.1 percent, and Latinos, 21.2 percent, was about 3 times the rate for Caucasians at 7.5 percent (Davies, n.d.) The 1998-2000 poverty rate of people who reported they were

American Indian or Alaska Native was 25.9 percent (Almanac of Policy Issues, 2001).

- Homelessness, like poverty, disproportionately affects members of minority groups (HUD, 2007). About 59 percent of the sheltered homeless population in 2007 and 55 percent of the population living in poverty were members of minority groups, compared with only 31 percent of the total U.S. population.
- With complex trauma and/or other psychiatric conditions, social marginalization and oppression often exacerbate or complicate symptoms (Briere & Spinazzola, 2009).

A survivor of multi-abuse trauma shares:

“I had to go back to my own Alaska Native values. I had to go back to my survival skills, because I fish and hunt with my children. I had to go back to those values and to think that I can survive. I can overcome. Because those activities – remaining active, building trust, building the process with children, building time with family – will help you recover.”

Internalized oppression occurs when people absorb society’s attitudes toward their group and direct those negative attitudes toward themselves:

- Internalized homophobia is associated with a lesbian/gay person’s devaluation of herself or himself, higher rates of concealing sexual orientation, greater depression and suicide risk, and other mental health and substance abuse problems (Green, 2007).
- Experiences related to racism and cultural oppression can alter a group’s collective identity, group-relational capabilities and societal worldview and can result in the emergence of projected self-hate onto other people in the group due

to the horizontal hostility that cannot be expressed directly to the ones in power (Comas-Diaz, 2007).

One can think of internalized oppression as the internalized police officer that keeps individuals in their socially prescribed place (Roy, 2007).

Trauma can also be passed from one generation to the next.

Experts use the term *intergenerational grief* to refer to grief passed on from the generation experiencing the trauma to their children even though the next generation may not be aware of or have direct experience of the actual traumatic event. Unresolved grief can be passed on from parents to children to grandchildren and so on (AIFACS, n.d.).

Historical trauma refers to cumulative trauma – collective and compounding emotional and psychological wounding both over the life span and across generations. In other

words, it is trauma upon trauma that occurs in history to a specific group of people, causing emotional and mental wounding both during their lives and in the generations that follow (AIFACS, n.d.).

When discussing intergenerational grief or historical trauma, many people point to the loss of language and culture. Naomi Michalsen, Executive Director of Women In Safe Homes in Ketchikan, AK, says:

“I always went to these meetings, listening to the elders saying, ‘We’ve lost our language.’ Or, ‘Our language is going to be lost.’ And at first I couldn’t relate that to me. But now it makes sense, because I learned some of my own family history. It makes a lot of sense. It *is* me. And it *does* mean a lot to me. And it *does* apply to me. But I think my generation and maybe even younger kids don’t know *how* it applies to them” (Michalsen, 2007).

For many Alaska Native people, the historical trauma is recent, having occurred during the lifetime of people still living. A survivor shares:

“When I was 12 years old, I had to leave my village to continue on with my education. The trauma that I experienced was leaving my community. I’d never left my grandmother. I’d never separated from my parents. The cultural shock, the experience that I went through, and not having it explained to me why I am there in a big school with over 6,000 students. And I had to pay someone a nickel or a quarter or a dime to try to learn the language that I’m speaking to you today. We had no choice. Back then, it was not explained why I needed to go. Instead my parents were told, ‘If you do not allow your child to go to this school, you will be incarcerated. You will be in jail.’ And my parents took that and believed that. So I had to leave my community.”

Shirley Moses, Shelter Manager at the Alaska Native Women’s Coalition in Fairbanks, AK, often discusses the issue of historical trauma when presenting domestic violence or sexual assault education in the villages her agency serves. She says:

“When we bring up the historical trauma, the effects of domestic violence and sexual assault on children, and the way it affects them, we see an *Aha!* where a light goes on. And we see whole councils, the health providers and teachers and young parents, saying, ‘I didn’t realize that was happening to me.’ We’ve had 10 suicides this past year. It could be that these children have been abused. They see layers we have never processed – the suicides, the violent deaths, the changes in our lifestyle. And they start talking openly. They say, ‘This is not okay. This is wrong. We need to start looking at ways to strengthen and get healthier.’ And they might start by just saying they want safe homes” (Moses, 2010).

“We have many layers, and we need to talk about all of them,” says Naomi Michalsen. “Maybe we’re not ready to, but at the same time, we need to know they’re there. Intergenerational trauma definitely needs to be healed. We have to find out what our history is. Or try to find as much as we can” (Michalsen, 2007).

Barriers to service

People from marginalized groups often find it hard to access social services – especially if most of the staff represent the dominant culture and services are based on the values and customs and beliefs of the dominant group. Here are some of the barriers:

- *Discrimination by staff or other people against individuals who are receiving services.* Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle, says:

“When it comes to homophobia, access issues are huge because people are so afraid of a woman loving a woman. For instance, having to share a room in a shelter with another woman becomes an issue for staff and for the people being served, whether that person has shown any inappropriate behavior or not. Racism is another huge issue that affects access to services, because we live in a society that responds to ‘normal’ based on what the provider’s view of normal is” (Foley, 2010).

- *Cultural barriers.* Different values and customs may make it difficult to access appropriate services. There may be language barriers, or customs that feel alien. Even the food served at a shelter or residential facility may be alien.
- *Conflicts over values.* A social service system with mostly Caucasian staff and dominated by Western ways of approaching issues may feel intimidating (Duran, 2006; Patterson-Sexson, 2010). Different providers may have different rules and priorities, some of which conflict – both with each other and with the culture of the person seeking services.
- *Trust issues.* People seeking help may not fully trust a provider from the dominant culture if they come from a different cultural background (Patterson-Sexson, 2010). There may be distrust between dominant and oppressed groups in the community as well. Someone who has experienced societal abuse or oppression may not trust providers because of bad experiences with authority figures such as teachers, previous social service providers or police who come from the dominant culture.
- *Fear of sanctions.* People with immigrant status may fear being deported if they lack documentation. An abusive partner or employer may have used this threat as a control tactic (Song & Thompson, 2005).
- *Fear of being discounted.* Allegations of discrimination or other forms of oppression are often dismissed by the larger society as “whining” or “playing the victim.” Other providers may have conveyed this attitude as well. Or providers may have blamed the individual for their problems based on stereotypes about the person’s race, culture, socioeconomic background or sexual orientation.
- *Fear of being judged.* An individual may have experienced being avoided or excluded because of misperceptions about race, culture, disabilities, socioeconomic background or sexual orientation. Other providers may have displayed conscious or unconscious bias or

SAFETY ISSUES: SOCIETAL ABUSE AND OPPRESSION

Being a member of an oppressed group can pose safety issues for people facing interpersonal violence:

- Some members of oppressed groups may be reluctant to report violence because of their community's negative experience with police (Foley, 2010).
- Fear of exposure – of being “outed” – may prevent lesbian, gay, bisexual or transgendered people from seeking help (IDHS, 2000).
- People with immigrant status may avoid seeking help for fear of being deported, especially if they disclose illegal immigration status (IDHS, 2000).
- Language barriers can increase isolation, making it more difficult to get help. A survivor shares:

“My father didn't speak English. We lived at, or below, the poverty level and this was another isolating factor for our family to get help.”

- Some victims of violence are reluctant to leave because of the disruption this would cause to family or community ties. Naomi Michalsen says:

“One of the comments I hear is, ‘You can't ask the man to leave because he's the owner of the house.’ So the woman would have to leave. And who wants to leave their home? Their village?” (Michalsen, 2007)

behaved in ways that betrayed stereotyped thinking. A person may also have experienced cultural values or customs being pathologized or even declared morally wrong when they differ from those of the dominant culture.

- *Fear of losing children.* Studies show that children are more likely to be removed from people of color. In the past, children were removed from Native Alaskan or American Indian families and placed in boarding schools (Duran, 2006). ICWA, the Indian Child Welfare Act, was enacted in 1978 because of the disproportionate numbers of Native children being taken from their families and adopted into non-Native families (Holley, 2011). Fear of losing one's children may also be active if lesbian/gay/bisexual/transsexual status, or disability status including substance use disorder or psychiatric illness is disclosed.
- *Fear of losing autonomous decision-making power.* Some people from marginalized

groups may have experienced providers from the dominant culture trying to impose their own customs or values. Providers may also have difficulty trusting people who seek their help because of stereotypes and conscious or unconscious bias, and may create rules and restrictions based on this lack of trust (Leal-Covey, 2011).

Empowering people from socially oppressed groups

Here are some ways to empower people from marginalized groups.

- Cultural competence is important in developing trauma-informed services. Trauma may have different meanings in different cultures, and traumatic stress may be expressed differently within different cultural frameworks. Therefore, it is important for providers within a trauma-informed system to work towards developing cultural and linguistic competence (Barrow et. al, 2009). Differing patterns of caregiving across racial and ethnic groups also strongly underscore the need for culturally relevant services (Nicholson et. al., 2001).

- Recognize the impact of societal oppression on wellness. Personal and relational needs, though essential, are insufficient for the development of wellness. Without satisfaction of collective needs, personal wellness can exist in limited form only. People require “well enough” social and political conditions, free of economic exploitation and human rights abuses, to experience quality of life (Prilleltensky, et. al., 2007).

- Respect spiritual needs. Some advocates and other professionals are uncomfortable with issues of religion and spirituality. However, many persons from marginalized groups view adherence to spiritual practices as resilience against adversity (Comas-Diaz, 2007). Tia Holley notes how important it is to ask what kind of spiritual support would be helpful:

“As a Native counselor at a Tribal treatment center who believes in spiritual diversity, I introduced alternative spiritual recovery options to participants in substance abuse treatment. I was surprised to find many of the Native participants in treatment had a strong Christian belief system. I learned to always ask about religious or spiritual belief preferences first rather than make assumptions. I found the 12 Steps helpful in many cases since they are drawn from many different belief systems from Atheist to Russian Orthodox, Christian, Buddhist and with the Great Spirit as a higher power” (Holley, 2011).

- Be aware of possible philosophical differences. For example, most “mainstream” psychological philosophies tend to promote individualism over collectivism, and many Western practitioners embrace a medical model for healing while indigenous cultures may believe that health is attained through the harmony of mind, body and spirit (Comas-Diaz, 2007).

Survivors share what helped them feel empowered:

AN ALASKA NATIVE SURVIVOR SPEAKS

Our traditional ways of communal living did not condone domestic violence, sexual assault or child abuse. Alcohol and drugs were not part of Native life. Even today there are more Native people who never drink or do drugs than there are Native alcoholics and addicts.

Acculturation and forced assimilation of Western values onto Traditional ways of living have caused a rift in family and community systems. Indigenous women, children and men have been disproportionately victimized and criminalized. Native women continue to be victimized, often by non-Native perpetrators. Our prisons hold a disproportionately high number of Native men, women and youth.

Overly conforming to Western standardization of care in the behavioral health field can be a form of internalized oppression. It is not empowering and less than helpful to believe the only reliable “cure” for behavioral health problems in Alaska is one based on theories and best practices created from within a limited Western worldview.

Traditional healing methods and effective Native service providers are essential in our field and must be included at all levels of care. Here in Alaska we are growing our own behavioral health professionals through culturally inclusive education programs such as Rural Human Services and I ask that agencies support their students in this endeavor so we can have the best of both worlds.

It takes more than taking a class, reading a book or watching a video to become “culturally competent.” Effective service providers research historical and ongoing treatment disparities as well as introduce themselves to local Native Tribes and create a working relationship based on respect. A great place to start is by calling your local ICWA (Indian Child Welfare Act) worker, or Tribal Cultural Program.

One survivor shares: “Learning some of these stories about what my great-grandmother had to go through and then my grandmother. My great-grandmother was abandoned. She didn’t have her family or anybody left. My grandmother was abandoned by her mother because of drinking and all the issues. My grandmother left my mom when she was younger, and my mother was raised with my Grandpa until she was 13. And so when I was having all these difficulties with my daughter, I was just thinking, “Wow, you know, she’s 13 or 14 and nobody’s done this before in my family. It’s the first time.” When you think about where we learned our stuff, it’s from our parents. It’s at the boarding schools where the parents were all abused. Some people had a great experience, but for my family, it wasn’t. So it was like a realization. I had this great feeling of sadness, because I hated my mom. In reality,

she was a survivor. My grandmother was a survivor. And my great-grandmother. So I have even more love for them for surviving.”

Another survivor shares: “What has been helpful for me is interacting with elders of my village, elders within my region. Elders are individuals with many years of experience. They’re less judgmental, less critical. They have big elephant ears ready to listen. ... I had to go back to my own Alaska Native values. I had to go back to my survival skills, because I fish and hunt with my children. I had to go back to those values and to think that I can survive. I can overcome. Because those activities – remaining active, building trust, building the process with children, building time with family – will help you recover. You will become a very strong individual, because I’ve become a very strong individual. I show it. I walk it. I talk it. I give it. It’s a light that we gain within ourselves when we start going through a healing process.”

Working with other providers

- Collaborate with indigenous providers, when available. Recognize and enlist the assistance of recognized helpers such as indigenous healers, elders or other leaders. Cultural ritualistic practices such as herbal cleansing, sweat lodges, pilgrimages, meditations and labyrinth walks are often useful in dealing with trauma and addressing low self-esteem (Comas-Diaz, 2007). Chemical dependency counselor/advocate Tia Holley shares:

“I found Native victims were much more comfortable and followed through more with ongoing service when a Native Advocate who was knowledgeable of cultural issues and cultural and community resources was present from the start when I worked as the Native Sexual Assault Advocate for our local Tribal Agency under the Stop Violence Against Native Women’s grant” (Holley, 2011).

- Provide cross-training for providers on diversity issues. Get to know the cultures in your area, as well as the groups that address LGBT issues or disability issues, and invite people from these cultures or groups to provide training for staff.
- There is a need for system-wide advocacy by advocates and other providers. Practitioners need to understand the structural roots of oppression within our larger society and engage in social action to promote social justice at the societal level (WHO/INPEA, 2002).
- Encourage individuals to get involved in groups that work for change within the system. Because oppression can lead to feelings of powerlessness, many trauma victims from marginalized groups find healing and transformation in activism. Ideological understanding and political consciousness of oppression, in addition to social activism, facilitates recovery and healing from discrimination and other forms of societal abuse (Comas-Diaz, 2007).

POVERTY

Poverty can present a formidable barrier to people trying to escape violence. This is particularly true for women and people of color.

Women in the United States are more likely to be poor than men. In 2007, 13.8 percent of women lived in poverty compared to 11.1 percent of men (Cawthorne, 2008). People of color face particularly high rates of poverty. African-American, Latino, Alaska Native and American Indian people all are about three times more likely than Caucasians to live in poverty (Davies, n.d.; Almanac of Policy Issues, 2001).

Many factors contribute to the high rate of poverty, including unequal opportunities in education and employment, the high number of jobs that do not provide adequate wages and benefits, the time many women devote to unpaid family care-giving, lack of access to affordable child care, insufficient child support and an inadequate network of public benefits (Montgomery County Commission for Women, 2009).

And employment does not always provide an escape from poverty. Employment statistics show that in 2002, women held 79.8% of lower wage jobs while men held 65.3% of managerial positions (US EEOC, 2002a). It is possible to work full-time at minimum wage and still have an annual income that falls below the poverty level if one has dependents.

The role of trauma in poverty

Violence and poverty are interwoven. Significant numbers of low-income people face interpersonal violence, and the violence they experience can make the climb out of poverty nearly impossible. Poverty, in turn, makes it more difficult to end violence and abuse, and to heal from their effects (Davies, n.d.).

Here are some of the ways trauma and poverty are interwoven:

- Studies show that over 50 percent of women receiving public assistance report having experienced physical abuse at some point in their adult lives, and most of these women also report a history of physical and/or sexual abuse in childhood (Lyons, 2000).
- Mental and physical health problems caused by violence or abuse, whether temporary or more long-term, can diminish some people's ability to work, participate in job training or education programs, or comply with government benefit requirements (Davies, n.d.).
- Efforts to escape violence can have a devastating economic impact, says Jill Davies in a policy and practice paper "Policy Blueprint on Domestic Violence and Poverty":

“Leaving a relationship might mean a woman will lose her job, housing, health care, child care, or access to the partner’s income. Often, criminal and civil legal remedies are necessary to safely leave a relationship. Criminal remedies typically have no monetary cost to the victim, but may take time away from work or job training, sometimes resulting in lost wages or loss of employment. The pursuit of civil legal strategies, such as divorce or custody actions, often drains family financial resources. Unable to afford litigation, some battered women concede financial and property demands in order to settle the case, further undermining their families’ security” (Davies, n.d.).

- Violence and abuse can push people into a cycle of poverty. Experiencing domestic or sexual violence can lead to job loss, poor health, and homelessness. It is estimated that victims of intimate partner violence collectively lose almost 8 million days of paid work each year because of the violence perpetrated against them by current or former partners (Cawthorne, 2008).
- Keep in mind that even in families that are not technically considered low-income, the victim of domestic violence may not have equal access to the family funds (Foley, 2010).

Barriers to service

People experiencing poverty may face a number of barriers when seeking help, either in the form of public assistance or safety from violence:

- *Fear of being judged.* Some people are reluctant to seek public assistance or disclose that they receive it because of repeated suggestions that they are lazy and simply need to pull themselves up by the bootstraps, or that their poverty is caused by poor spending decisions, bad behavior or lack of moral character. People living in poverty often have encountered service providers or other people who minimize the degree of hardship that they experience on a limited income.
- *Fear of being denied services.* People who receive TANF or other public assistance may be reluctant to disclose domestic violence to these providers because they fear losing benefits if it is discovered they are living with a partner. A recent study found that approximately 70% of domestic violence victims did not disclose the abuse to their TANF caseworkers (Satyanathan & Pollack, n.d.). The same study found that 75% of those that did reveal information about the violence did not receive the appropriate support or services.
- *Barriers to employment.* Some social service programs require that an individual be seeking employment or participate in “work readiness” activities as a condition for receiving services. Victims of domestic violence who receive public assistance may not be able to leave welfare for work within the time constraints imposed by welfare reform for a variety of reasons. These include the psychological effects of domestic violence (such as depression or anxiety), and sabotage and manipulation by the abuser

SAFETY ISSUES: POVERTY

A person experiencing poverty may find it much more difficult to implement a safety plan. Jill Davies says:

“A woman must be able to financially support herself and her children after leaving an abusive partner. In many locations there are programs that provide housing, temporary cash assistance, child care, and free legal representation. However, most of these programs have limited funding, offer short-term resources, and regularly turn away applicants. As a result, some low-income battered women simply are without the income, government support, or access to services necessary to fully implement a safety plan” (Davies, n.d.).

To promote safety, be aware of the unintended consequences of standard interventions, Davies says. Each person experiencing domestic violence has a unique set of circumstances. Some face life-threatening violence and others much less severe forms of abuse and control. For some victims, prosecuting an abuser brings increased protection, but for victims who face poverty, prosecution may bring more hardship than help, particularly if loss of the abuser’s job would mean a loss of financial support.

(interference with child care, harassment at work, or leaving marks or bruises that prevent the victim from going to work). These issues can lead to tardiness, absenteeism and lack of productivity – and ultimately to loss of a job (Satyanathan & Pollack, n.d.).

- *Inability to afford services.* Even if services such as domestic violence advocacy, sexual assault counseling or mental health services are offered free of charge by advocates or other professionals, some people may not be able to afford babysitting costs or transportation to get to appointments. A fragmented system makes services harder to access, particularly for people who must use public transportation or lack transportation altogether.

Empowering people who are experiencing poverty

Here are some ways to empower people who are experiencing poverty:

- Tailor plans to an individual’s needs. For some low-income people, obtaining housing is the largest challenge, and for others it may be finding employment or health care. Some have strong support networks while others have little support. Systems tend to respond to people facing interpersonal violence as if they share common experiences, languages, abilities, and cultures. This is not the case. Some survivors will access and use

systems differently, and some may wish to avoid a particular system altogether (Davies, n.d.). Shirley Moses, Shelter Manager at the Alaska Native Women's Coalition in Fairbanks, AK, says:

“The women that we see are very fiercely independent for the most part. They can't get unemployment a lot of times, or they can't even get housing or Medicaid or anything, unless they have an address to go to. Sometimes we will take them just long enough for them to apply for all those things, and then they transition to family. Once they have a mailing address or someplace stable, they can apply for that and then get it. Most of them will then transition to a place that is not identified as a place where they are getting welfare. They want to be on their own. They want to take care of themselves” (Moses, 2010).

- Respect autonomy. Assist people in defining their own needs, so they can make informed decisions and choices and actively participate in strategies to enhance their financial security and safety. Many systems look for opportunities to provide uniform or even automated services. In this context, providing several generalized categories of responses with an opportunity to choose among them or opt out of them altogether offers a step toward more effective interventions. Paperwork and automated services can also create a barrier for survivors experiencing literacy, language or technology challenges.

Working with other providers

When working with other providers:

- Include financial advocacy as part of services. Ensure that advocates have the tools, training, resources and supervision necessary to provide financial advocacy (Davies, n.d.). Advocates and other providers should know how to explain resources such as TANF, WIC, subsidized housing and other options available for low-income people. They should help victims of violence access these resources, and be able to provide meaningful referrals to other sources of information and assistance. If necessary, invite these other resource providers to conduct in-house training for staff.
- Refer to appropriate legal assistance that can advise on options. The federal government has responded to the problem of domestic violence and poverty by allowing states to adopt the Family Violence Option (FVO). Under the FVO, victims of domestic violence would be allowed an extended time-period to obtain employment. States that have chosen not to adopt the FVO may have other provisions for domestic violence in their welfare legislation such as allowing agencies to provide a renewable work exemption waiver for victims of domestic violence (Satyanathan & Pollack, n.d.).
- Assess for untreated medical conditions and make appropriate referrals. People living in poverty often present with untreated medical problems, and may have trouble accessing the medical system because they don't have insurance, many doctors don't accept Medicaid, or their abuser prevents them from seeking medical attention. There are

clinics in many urban areas that might also be options. Know your community's medical resources (Obtinario, 2010).

- Increase advocacy at the systemic level. Montgomery County (Maryland) Commission for Women (2009) recommended several public policy changes that would ease the burden of poverty for single mothers. These include a living wage, pay equity, expanded family tax credits, paid sick leave and dependent care leave, and flexible work schedules so that those who have jobs can balance work and family needs.
- Examine your own program's policies and encourage other agencies and policy makers to do so as well. Policy should focus on financial safety as well as physical safety, says Jill Davies:

“Legislation, policy, services, and advocacy often focus on physically separating battered women and their children from the abusive partner, but do not guarantee that there will be a roof over their heads, food on their table, or health care available when they need it. Reducing the risk of physical violence will not make battered women and their children ‘safe’ without also providing opportunity for long-term financial stability” (Davies, n.d.).

HOMELESSNESS

Defining the scope of homelessness has proven controversial since the issue first gained broad public attention during the 1980s. Public debate has revolved around how widely to view the scope of “residential instability” and how to target scarce resources to address it. In general, the U.S. Department of Housing and Urban Development (HUD) divides “residential instability” into two broad categories: “literally homeless” and “precariously housed” (HUD, 2007):

- *Literally homeless.* This includes people who for various reasons have found it necessary to live in emergency shelters or transitional housing for some period of time. This category also includes people who sleep in places not meant for human habitation (for example, streets, parks, abandoned buildings, and subway tunnels). People who are “street homeless” may also use shelters on an intermittent basis.
- *Precariously housed.* This includes people on the brink of homelessness. They may be doubled up with friends and relatives or paying extremely high proportions of their resources for rent. They are often characterized as being at imminent risk of becoming homeless.

HUD’s definition of a person who is “chronically homeless” is an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation – e.g., living on the streets – or in an emergency homeless shelter (National Alliance to End Homelessness, 2007).

According to estimates by the *2007 Annual Homeless Assessment Report to Congress* (HUD, 2007), the number of people who were living in shelters or were unsheltered in January 2005 totaled 754,147. Of those, an estimated 338,781 were living on the streets, in cars, or in other areas not meant for human habitation. These figures do not include those who are “precariously housed.”

The role of trauma in homelessness

Homelessness can be a direct result of trauma:

- Among cities surveyed by the U.S. Conference of Mayors in 2003, 44 percent identified domestic violence as a primary cause of homelessness (National Network to End Domestic Violence, 2004).
- One study found that 92% of homeless women have experienced severe physical or sexual abuse at some point in their lives. Of all women and children who are homeless,

60 percent have been abused by age 12, and 63 percent have been victims of intimate partner violence as adults (National Network to End Domestic Violence, 2004).

- Significant numbers of people who are homeless have been exposed to neglect, psychological abuse, physical abuse, and sexual abuse during childhood; community violence; combat-related traumas; domestic violence; sexual assault; and accidents or disasters (Barrow et. al., 2009).
- Research also shows that severe mental illness and chronic substance use disorder are risk factors for homelessness (HUD, 2007). The Annual Homeless Assessment Report sample data suggests that 25 percent of all adults living in homeless shelters are people with disabilities. An estimated 5.4 million adults have co-occurring mental health and addiction disorders. Of adults using homeless services, 31 percent report having a combination of these conditions (NAMI, 2007).

Homelessness itself is a traumatic experience. Individuals and families who are homeless are under constant stress, often unsure of where they will sleep at night or where they will get their next meal (Barrow et. al., 2009).

Homelessness, like poverty, disproportionately affects people of color (HUD, 2007). About 59 percent of people who were homeless and living in shelters in 2007 were people of color, compared with only 31 percent of the total U.S. population. African-Americans constitute 12 percent of the total U.S. population but 45 percent of people who are homeless.

Barriers to service

People who are homeless face a number of barriers when seeking services:

- *Stigma.* People who are homeless may have confronted attitudes from the public or the media asserting that most homeless people are homeless by choice. They may have heard repeated suggestions that they are lazy and need to pull themselves up by the bootstraps, or that their homelessness is caused by poor decisions, bad behavior or lack of moral character.
- *No telephone or permanent address.* With no phone number or address to put on forms, people may find it impossible to apply for benefits such as public aid. Potential landlords, or employers who want to schedule a job interview, can't make contact. Employers may not want to hire, and landlords may not want to rent to, people with no permanent address because they appear "unstable." And social service agencies may have difficulty staying in contact for the purpose of providing services. Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at S.T.A.R. in Anchorage, AK, says:

"I'm going to have a very difficult time maintaining communication if they are not able to maintain a phone, if they are not able to maintain a residency. If they are

SAFETY ISSUES: HOMELESSNESS

Victims of violence or abuse who are homeless may find it difficult to implement any kind of meaningful safety planning.

- Despite the fact that many people become homeless as a direct result of fleeing domestic violence, some domestic violence shelters have refused services to individuals who are “only” homeless. Because of this, people may be reluctant to disclose to advocates that they are homeless, which in turn would allow them to get referrals for needed services.
- Experiences of sexual harassment and sexual assault are common for women living on the street or in homeless shelters. Homelessness is a much more dangerous condition for women (Lenon, 2000).
- Women’s homelessness is often “invisible” because women may rely on their domestic and sexual roles as a strategy to avoid shelters, such as taking up temporary residence in short-term sexual relationships (Lenon, 2000).
- People living in subsidized housing may be afraid to disclose abuse because of fear that they will be evicted if authorities discover they have a partner staying in the home. Seattle-based behavioral health specialist Karen Foley (2010) relates:

“I had someone in a housing program who was trying to get clean and sober. She had a year in recovery, and her partner found her. When he found her, he holed himself up in her son’s bedroom and was using drugs. She was so excited because she wasn’t using, and she was really upset and scared to tell her housing provider that he was there, because the consequences were so severe. Even though she didn’t give out her address, her family did. The police wouldn’t do anything to get rid of him, because his belongings were there and they considered that he lived there. Here was somebody who was well on her way to recovery and safety, and she ended up homeless again because her perpetrator found her.”

Do not let a person’s homeless status discourage you from safety planning (Obtinario, 2010). In fact, safety planning becomes even more imperative due to the increased vulnerability homelessness creates. Discuss:

- What are some of the places the abuser frequents?
- Are there other resources available where the individual will be less likely to encounter the abuser?

couch-hopping and I can't track them down, then that's a huge barrier" (Patterson-Sexson, 2010).

- *Restrictions on length of shelter stays.* The average stay at an emergency shelter is 60 days, while the average length of time it takes for a homeless family to secure housing is 6-10 months. Many domestic violence shelters are unable to house families longer than 30 days to allow space for individuals in immediate danger (National Network to End Domestic Violence, 2004).
- *Confusion over how to access services.* One study found that people who are homeless and have a psychiatric condition are often confused over how to access and use available services. The more severe the psychiatric symptoms, the greater the level of confusion (Rosenheck & Lam, 1997).
- *Inaccessibility of services.* Other barriers identified in the Rosenheck & Lam study (1997) included not knowing where to go for services, inability to afford services, and too much of a hassle or too long a wait for services. There are not enough federal housing rent vouchers available to accommodate the number of people in need. Some people remain on a waiting list for years, while some lists are closed (National Network to End Domestic Violence, 2004).

Shirley Moses, Shelter Manager at the Alaska Native Women's Coalition in Fairbanks, AK, says individuals from rural or remote areas face especially difficult challenges:

"They are homeless. They come in from a village and they don't have money to go home. Or they don't feel safe going home. They haven't gotten access to public housing and they don't have money for first and last month's rent and utilities. They don't have the financial stability where they have established credit needed for housing. They haven't had to rent, so they don't have the landlord history. Or they've had assault charges and they are not eligible for low-income housing. Or when a potential landlord pulls their name up, three or four criminal violations pop up. It's usually domestic violence or something related where they've been charged, and landlords will refuse to rent to them. Or if they come here and have enough money for four or five months – they've gotten their dividend to pay initially – they end up going home because they haven't been able to find a job. They might have worked at the tribal office but they can't tie their skills into working in a secretarial setting or other job in an urban job setting" (Moses, 2010).

Empowering people who are homeless

Here are some ways to empower people who are homeless:

- Recognize that stable housing is key to escaping violence. Helping victims of domestic violence to access and maintain transitional and permanent housing allows them to attain safety and self-sufficiency. Transitional housing resources and services provide an essential continuum between emergency shelter provision and independent living. In one

study, a majority of women in transitional housing programs stated that had these programs not existed, they would have likely gone back to their abusers (National Network to End Domestic Violence, 2004).

- Improve community outreach efforts. Taking services to homeless individuals – either on the streets or at meal sites or other places where homeless people congregate – often works better than waiting for them to come to you. Sustained community outreach efforts can facilitate access to services and help overcome barriers, especially if homelessness is accompanied by psychiatric issues (Rosenheck & Lam, 1997).

Working with other providers

When working with other providers:

- Join consortiums or continuum of care organizations. Take advantage of opportunities to participate in “continuum of care” organizations made up of community agencies that address homelessness issues. This not only allows advocates and other providers to keep abreast of new services that become available, but also makes other agencies aware of your services and the needs of the people you serve. Participation in these organizations can also be invaluable for accessing grants and other funding.
- Increase advocacy at the systemic level. If housing were inexpensive, or people could earn enough to afford housing, very few individuals would face homelessness. But housing costs have risen steadily across the country and skyrocketed in many areas. At the same time, people with little education or job training find it increasingly difficult to earn enough money to raise their incomes above the poverty level, even if they are employed full-time and work overtime. Only jobs that pay a living wage and policies that expand the availability of affordable housing to people with below-poverty incomes will ensure stable homes for these individuals (Burt, 2001).

Shirley Moses, at the Alaska Native Women’s Coalition, discusses efforts to connect with other organizations to reduce homelessness for women from rural and remote areas:

“If they come into shelter, we have several employers who have given us the opportunity to have them shadow, to give them work-study supported employment opportunities. We work with them to get Pell grants or other grants if they want to stay in town and go to school, and financial aid so they can have that opportunity and get stable housing.” (Moses, 2010).

SEX TRAFFICKING

Considerable controversy exists over the best term to describe the commercial sex trade. Is the appropriate term *prostitution*? *Sex work*? *Sex trafficking*? Advocates and other providers have an understandable desire to reduce the stigma that attaches to words such as *prostitution*. However, the downside to a neutral-sounding term such as *sex work* is the implication that participation in commercial sex is a freely-made choice, when in fact many have been forced into it.

Critics such as Farley (2003) assert that the portrayal of commercial sex as consensual on the part of all parties denies or trivializes its harm to a large number of participants. Farley argues that exploitation by the sex industry is a form of sexual violence which results in economic profit for perpetrators, and that – like slavery – commercial sex is “a lucrative form of oppression of human beings.”

According to Farley, poverty, racism and sexism are inextricably connected in exploitation by the sex industry. Individuals are purchased because they are vulnerable due to lack of educational options, previous physical and emotional harm, and toxic ethnic and racial stereotypes.

Human trafficking is best understood as modern-day slavery (Song & Thompson, 2005). Children and adults are trafficked into sweatshops, domestic servitude, commercial sex, farm labor, begging, construction and many other forms of labor. *Sex trafficking* is a subset of human trafficking in which a commercial sex act is induced by force, fraud or coercion, or in which the person induced to perform such an act has not attained 18 years of age.

For purposes of this manual, we will be discussing work in the sex industry that is not freely chosen by the individuals involved, or would not be chosen if they thought they had any other viable options.

Trauma and sex trafficking

Sex trafficking “is rampant in the intersection between violence, addiction and mental health issues,” says Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle. “Sex trafficking is often part of that package” (Foley, 2010).

Many similarities exist between survivors of domestic violence and survivors of sex trafficking:

- The range of tactics used by the perpetrators of trafficking and domestic violence are similar and include: physical and emotional violence; isolation; financial abuse; threats to persons, family and others; withholding of food, sleep and medical care; sexual abuse and

exploitation; and using children to manipulate and control their victims (Song & Thompson, 2005).

- Quite often, victims of trafficking suffer multiple victimizations that include domestic, intimate partner, or relational violence. Victims of trafficking are raped, kidnapped, beaten, threatened and exploited in extreme and horrific ways (Song & Thompson, 2005).
- Although not all survivors of childhood sexual abuse are recruited into commercial sex, most people being exploited by the sex industry have a history of sexual abuse as children, usually by several people (Farley, 2003).
- One study found that 66 percent of people involved in commercial sex were victims of child sexual abuse. Women who were sexually abused as children are four times more likely than women who haven't been abused to work in the commercial sex industry, while men who were sexually abused as children are eight times more likely to do so (ICASA, 2001).
- Seventy-five percent of those involved in commercial sex have been homeless at some point in their lives.
- Dissociative disorders, depression and other mood disorders are common among individuals involved in street, escort, and strip club forms of commercial sex, according to Farley (2003). She says most individuals report that they cannot do the work unless they dissociate. Chemical dissociation aids psychological dissociation, and functions as an analgesic for injuries from violence. When individuals being exploited by commercial sex do not dissociate, they are at risk for being overwhelmed with pain, shame and rage.
- The constant verbal humiliation, the social indignity and contempt, and the physical violence of commercial sex exploitation and trafficking can result in personality changes which have been described as complex post-traumatic stress disorder (Herman 1997).

Barriers to service

One of the biggest barriers to appropriate services is the invisibility of people victimized by sex trafficking and exploited by the sex industry (Farley, 2003). People involved in commercial sex or sex trafficking may face several obstacles:

- Fear drives invisibility. In addition to fear of prosecution for engaging in commercial sex, people victimized by human trafficking or sex trafficking may fear being deported if they have immigrant status and lack documentation. Individuals may fear that disclosure of commercial sex or other illegal activity may trigger an investigation by a child welfare agency. They may fear retaliation from a pimp or from captors if they are a victim of sex trafficking or human trafficking.
- Some people to whom they turn for help may deny that a person engaged in

SAFETY ISSUES: SEX TRAFFICKING

People experiencing sex trafficking and exploitation by the sex industry face a number of safety issues:

- Like many victims of domestic violence, victims of sex trafficking lack access to money, “systems” or people who could help them to escape (Song & Thompson, 2005).
- Individuals victimized in the sex industry may be unaware that they are able to access domestic violence or sexual assault advocacy services after experiencing violence on the job. When they do seek support, they may experience judgment from those who are in a position to respond to the interpersonal violence (Haskell, 2010).
- People exploited by the sex industry are often reluctant to report violence to authorities for fear of prosecution or the belief that their complaints won’t be taken seriously, and in some cases, they may face more violence from the police officers they turn to for help (Haskell, 2010).
- Victims may feel compelled to conceal their occupation from advocates and other providers because of house rules such as curfews. As a result, advocates miss out on opportunities to develop safety plans tailored to the individual’s situation (Haskell, 2010).
- Individuals engaged in commercial sex are often prevented from using condoms or practicing safe sex. Seattle-based behavioral health specialist Karen Foley says:

“What comes with [commercial sex] are sexually transmitted infections, including HIV and AIDS and hepatitis C, and those messages from partners that no one else will have them. I see that all the time. Also, situations where the perpetrator won’t let her use a condom or other means to protect herself” (Foley, 2010).

If an individual is not ready, or doesn’t feel able, to leave the sex industry at this time, explore safety options that reduce risk. For example, sex workers in some communities act as “lookouts” for each other, or keep a “bad johns” list of customers who are violent (Obtinario, 2010). Explore options that help the individual control the situation, such as choosing the place where encounters take place and having a back-up plan if things go wrong (Obtinario, 2010).

commercial sex can be raped. Other providers may have suggested that the victim asked for rape or other violence, and police may even imply that an individual is merely upset about not getting paid.

- People involved in commercial sex may be barred from services by providers who fear their behavior will be disruptive.
- Some people have experienced other participants in support groups such as A.A. – or even some unscrupulous providers – “coming on” to them once their involvement in the sex industry is revealed.

Empowering people affected by sex trafficking

Here are some ways to empower people victimized by sex trafficking or exploitation by the sex industry:

- As with victims of domestic violence and other forms of trauma, the first goal with people seeking to leave the sex industry is to establish physical safety. Only after that has occurred (often by providing safe housing), can other issues such as substance dependence and complex trauma be addressed (Farley, 2003).
- Farley (2003) stresses the need for intake inquiry regarding a history of exploitation by the sex industry. Unless advocates ask screening questions, she says, this type of victimization will remain invisible. Questions she suggests include: “Have you ever exchanged sex for money or clothes, food, housing or drugs?” and “Have you ever worked in the commercial sex industry: for example, dancing, escort, massage, prostitution, pornography or phone sex?”
- Avoid judgmental attitudes. Recognize that the individual may have originally been coerced into the sex industry and that participation is not always the person’s choice. In commercial sex, the conditions which make genuine consent possible are often absent: physical safety, equal power with customers, and real alternatives (Farley, 2003). Understand that some people – even if they weren’t technically coerced – experience commercial sex as a means of survival (Haskell, 2010).
- Include outreach services that meet individuals where they are. Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at S.T.A.R. in Anchorage, AK, says:

“We work right above a free HIV/AIDS testing clinic, and I know we get a lot of folks who will come up and pop in, seeking services, who we know are being sent to the HIV/AIDS testing clinic by their pimps. And if women have a moment without an eye being on them, they are sneaking up to our office and getting some information” (Patterson-Sexson, 2010).
- Respect autonomy. Use a person-centered, harm reduction approach, focusing only on those issues where an individual has indicated a desire for support (Haskell, 2010).

Working with other providers

When working with other providers:

- Educate about trauma. Educate police and others in the criminal justice system, as well as other social service providers, about the trauma issues that can lead to exploitation by the sex industry as well as trauma issues stemming from it, and encourage others to take the survivor's issues seriously.
- Refer to appropriate legal assistance. Victims of trafficking may be entitled to assistance under the Trafficking Victims Protection Act of 2000 (TVPA), amended in 2003 by the Trafficking Victims Protection Reauthorization Act. The TVPA provides critical protections survivors need to assist in the investigation and prosecution of their traffickers and may also provide immigration protections if the victim of trafficking is from outside the U.S. (Song & Thompson, 2005).

INCARCERATION

For purposes of this document, “incarceration” means being held in a state or federal prison, local jail, work camp or youth detention center.

The population of women in state and federal prisons is growing. As of June 2004, women accounted for 6.9 percent of all inmates nationwide; there were 103,310 women in state or federal prisons. Since 1995, the number of female inmates has grown by average of 5 percent per year (Bureau of Justice Statistics, April 2005).

The majority of female prisoners are serving time for property crimes and drug offenses, rather than violent crimes. Many of the violent crimes committed by women are against a spouse, ex-spouse, or partner; women often report having been physically and/or sexually abused by the person they assaulted (Covington, 2002; O’Brien, 2001).

The role of trauma in incarceration

Incarcerated women have a history of trauma at much higher rates than the general population. The rate of physical or sexual abuse or violence experienced by incarcerated women, either within their families or by intimate partners, is quite high – estimates vary from 44 percent to 80 percent – compared to that reported by women in the general population – a 30 percent lifetime occurrence (O’Brien, 2002).

Being victimized by interpersonal violence may lead to behavior that causes people to be incarcerated. The Illinois Clemency Project for Battered Women found that the state often incarcerates women for actions directly or indirectly relating to abuse against them (VanNatta & Byrne, n.d.). Examples offered by the Clemency Project include:

- When adolescents run away from home to escape abuse and turn to theft and prostitution to support themselves.
- When a victim kills or seriously injures the batterer by using physical force to defend against an attack.
- When a batterer commits a crime in the presence of the victim, who is then considered an accomplice. Often, victims are convicted based on “accountability,” even though they were coerced into assisting the perpetrator.
- When a batterer attacks or kills the victim’s child and the victim is considered accountable for “failure to protect” the child.
- When a victim of violence or abuse begins to use illegal drugs to medicate pain.

SAFETY ISSUES: INCARCERATION

People who are, or have been, incarcerated face some special safety issues:

- Some individuals return to abusers upon release because they have nowhere else to go.
- Some people are released into other dangerous situations as well. “Here, they will release someone from jail onto the street, and it’s at midnight, in a bad neighborhood,” says behavioral health specialist Karen Foley (2010). “There’s no concern about releasing someone to the streets.”
- People subject to electronic monitoring may be restricted in terms of where they can go to escape an abuser.
- Rapes and other forms of nonconsensual sexual contact carried out by corrections personnel or other inmates are widespread. A study investigating rates of sexual abuse at three Midwestern prisons for women found rates of sexual abuse as high as 19 percent. A little more than half of the reported perpetrators were staff (National Prison Rape Elimination Commission Report, 2009). In a study of inmates at a Midwestern state prison, 22 percent of male respondents said they had been forced to have sexual contact against their will at least once while incarcerated (ICASA, 2001).

- When an abusive partner or pimp forces the victim into commercial sex.

In many of these cases, the Clemency Project found that the abuse perpetrated by the batterer against the defendant is not adequately considered at trial or sentencing. Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle, says:

“When it comes to incarceration, many of the people we serve are forced to take the rap for their partner. It doesn’t help that there’s the third strike law, and they end up taking the rap for things they weren’t even involved in. In other situations, I’ve had people that were arrested as a victim defendant because they left a mark. For instance, their nails left a mark on the perpetrator’s neck or hands when the perpetrator was trying to strangle them, and they end up being the one who’s incarcerated.”

A significant percentage of incarcerated individuals also contend with co-occurring issues such as substance use disorders, mental health issues, poverty and homelessness.

- Approximately 80 percent of women in state prisons have substance-abuse problems, and nearly one in three women serving time in state prisons report having committed their offenses in order to obtain money to support a drug habit (Covington, 2002).
- Nearly 23 percent of women inmates nationwide have a psychiatric diagnosis (Correctional Association of New York, 2005).
- One study found that about 37 percent of women prisoners had incomes of less than \$600 per month prior to their arrest (Correctional Association of New York, 2005).
- The Chicago Coalition for the Homeless in their ‘snapshot’ survey of women detained at Cook County Detention Center found that 54% reported being homeless in the 30 days prior to entering the jail (O’Brien, 2002).

The experience of being incarcerated can create additional trauma for many people. Individuals who have been incarcerated – especially if they have been incarcerated more than once – may suffer from post incarceration syndrome, a form of posttraumatic stress disorder stemming from the incarceration experience itself (Gorski, 2001).

Gorski (2001) defines *post incarceration syndrome* as a set of symptoms present in many currently incarcerated and recently released prisoners that are caused by being subjected to prolonged incarceration in environments of punishment with few opportunities for education, job training, or rehabilitation. The symptoms are most severe in prisoners subjected to prolonged solitary confinement and severe institutional abuse.

People traumatized by the incarceration experience are at a high risk for developing substance dependence, relapsing to substance use if they were previously addicted, relapsing to active psychiatric symptoms if they had previous mental health issues, and chronic unemployment and homelessness (Gorski, 2001).

Barriers to service

In a policy paper written for Chicago’s SAFER Foundation, Patricia O’Brien, Ph.D., identifies several obstacles faced by incarcerated individuals seeking to reintegrate into their communities:

- *Reestablishing a home and family life.* This may include regaining legal and physical custody of children, and making decisions about continuing prior intimate relationships, which may have been exploitative, or sexually or physically abusive.
- *Meeting basic needs.* Finding affordable housing, securing employment that pays a sufficient income to support oneself and a family, or getting public assistance may require people to negotiate the stigmatized perception of ex-prisoners by the general public — potential employers, landlords and community members. People who have been incarcerated may be barred from certain jobs, housing, public assistance or other benefits because of their criminal record.

- *Fulfilling the multiple conditions of a parole plan.* This may include getting a job within a certain period of time, participating in treatment or support group meetings to ensure continued recovery from alcohol or drug addiction and not getting into any additional legal difficulties.

Staff may face some major barriers as well, when seeking to help people who are, or have been, incarcerated:

- *Trust issues.* Many incarcerated people have had repeated negative experiences with authority figures – abuse and even rape by prison guards is not uncommon. Individuals may fear that disclosing drug abuse or other problems will get them sent back to prison. They may have experienced people being afraid of them when it is discovered that they have been incarcerated. They may fear retaliation if they report any kind of abusive behavior in an institutional setting.
- *Fragmented services.* If services in the larger community are often fragmented, this is even more true within the criminal justice system. In some cases, social service providers who work with incarcerated people inside a prison are forbidden from serving the same individuals after they've been released. This can make follow-up services difficult or impossible.

Empowering people who have been incarcerated

In *A Woman's Journey Home: Challenges For Female Offenders And Their Children*, Stephanie Covington recommends “wraparound” social services to meet the multiple interconnected needs of individuals involved in the criminal justice system, including job training, education, substance-abuse and mental health treatment, and parenting issues. She adds that individuals leaving jail or prison also need relationships with people who care and listen and can be trusted (Covington, 2002). Here are some ways to empower people who are or have been incarcerated:

- **Affirm autonomy and the right to control decision-making.** In prison or jail, obedience to authority is the core value. Inmates are told what to do from the time they get up until the time they go to sleep. What they are not allowed to do is make their own decisions. When people are released, suddenly they are expected to make dozens of decisions in a short period of time, and they may experience problems with independent decision-making. Present options and help the individual sort through them (Wong, 2007).
- **Validate frustrations.** Employers often do not want to hire people with a conviction record and landlords don't want to rent to them. Therefore, finding a job and a place to live may be much harder than it is for others. People with conviction records may be rejected over and over before they are successful. As with other people, rejection is painful (Wong, 2007).
- **Recognize the ways in which many “offenders” have been victimized themselves at some point in their lives.** Help individuals sort out “what's mine” and “what's not mine”

in terms of responsibility. It may be helpful to think of responsibility as “the ability to respond.” We are responsible for things that are under our control, including our own decisions where we are able to make them. We are not responsible for things over which we have no control, such as another person’s behavior.

- Avoid polarized thinking. Some providers have a mindset that says, “If I let this person talk about what’s been done to them, they’ll never take an ounce of personal responsibility for their own behavior.” This is not necessarily true. In fact, people are often more willing to own up to their mistakes when they can trust that we are willing to listen to their side of the story.
- Role-play difficult situations. Rehearse how to handle questions about a conviction record during job interviews or from a potential landlord.

Working with other providers

Social service providers and criminal justice personnel quite often have different philosophies. While the criminal justice system is often focused on punishment and accountability, advocates and other social service providers may be focused on healing and empowerment. Because of these differences, the relationship between social service providers and criminal justice personnel is often marked by mutual distrust. Criminal justice providers are labeled as overly harsh, while advocates and other social service providers are labeled naïve.

When working with providers in the criminal justice system:

- Educate about trauma. Many incarcerated victims of violence suffered traumatic experiences in their lives long before they developed the coping mechanisms that may have led to their incarceration or other involvement with the criminal justice system. Educate corrections personnel, parole or probation officers and others in the criminal justice system about the trauma that often exists in the lives of people who have been incarcerated. Help providers understand that taking victimization issues seriously does not undermine an individual’s ability to take responsibility for decisions and actions where this is appropriate.
- Emphasize areas of agreement. Advocates, other social service providers and criminal justice personnel have a mutual interest in preventing recidivism. All parties will recognize the need for better housing and employment opportunities for formerly incarcerated people. Emphasize that helping survivors of violence get the help they need to heal from past abuse or trauma can go a long way toward reducing recidivism.

WORKING WITH OTHER PROVIDERS

Every program has strengths and challenges impacting our ability to provide services. Unfortunately many victim's advocacy programs are under-equipped to address co-occurring issues impacting safety and health such as substance use disorders, mental health concerns or disability issues. Similarly, service providers who address other issues often struggle when addressing domestic violence, sexual assault and other trauma-related issues.

One of the challenges presented by multi-abuse trauma – for providers from all disciplines – is its complexity. Multi-abuse trauma defies simple, quick-fix, one-size-fits-all solutions. Cooperation between providers is crucial in order to address the multiple issues involved. All providers need to expand current practices and explore new strategies for working together to address safety, sobriety, wellness and justice.

Advantages of working with other providers

Addressing multiple co-occurring issues requires the inclusion of providers from diverse backgrounds and disciplines. Working in partnerships, collaborations and coalitions with other community providers offers several advantages for everyone involved:

- Working in partnership with others, while challenging, can be a powerful tool for mobilizing individuals and groups to action, bringing community issues to prominence and developing policies (Cohen, Baer and Satterwhite, 2002).
- Community coalitions and collaborations can help everyone remain up to date on what other providers are doing regarding a particular issue, as well as what resources are available in the community to address the issue (Cohen and Gould, 2003).
- Rather than creating new projects or programs, such associations can help everyone avoid duplication of services, and thereby avoid wasting scarce resources (Cohen, Baer and Satterwhite, 2002).
- Effective coalitions can accomplish a broad range of goals that reach beyond the scope and capacity of any one single institution or organization (Cohen & Gould, 2003).
- More and more, funders are requiring that provider groups work together to solve a problem (Cohen & Gould, 2003).
- Perhaps most importantly, establishing relationships with a variety of other providers can help all of us provide more and better services. A survivor shares the impact on her when a domestic violence agency developed an ongoing relationship with a dentist in the community:

“There’s a program called Give A Smile Back, and it’s pro bono. You had to have damage done to your teeth by domestic violence. They are putting several thousand dollars worth of work in my mouth, and they are giving me my smile back.”

Partnerships and collaborations also can help us improve our outreach efforts. Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at Standing Together Against Rape (S.T.A.R.) in Anchorage, AK, says:

“We go into the psychiatric institute and the correctional facilities, and work closely with our forensic nurses. We have great connections with our military branches. We have a strong partnership with our school district. Those have all been helpful tools in not only spreading our preventive education, but also connecting with survivors.”

Barriers to cooperation among providers

Unfortunately, human services have never been organized into coherent systems; rather, domestic violence, mental health, substance abuse, child welfare, and other providers are each organized as systems unto themselves with different funding and accountability structures. Developing linkages or collaborating across these sectors is fraught with difficult problems, and many barriers to cooperation exist:

- *Fragmentation of services.* Because social service systems in many communities are fragmented, providers themselves may have trouble keeping up with what’s available. Providers may experience problems when trying to access other services on behalf of people they serve. As one example: In some states, social service providers who work with incarcerated people inside a prison are forbidden from serving the same individuals after they’ve been released. This can make follow-up services difficult or impossible.
- *Lack of trust.* Providers from different disciplines such as victim’s advocates, substance abuse counselors, mental health providers and criminal justice personnel often have differing philosophies and theoretical orientations and may not trust each other because of this (Warshaw et. al., 2003). For example, drug and alcohol treatment providers may be focused on accountability, while the criminal justice system is often focused on punishment and victim’s advocates are focused on healing and empowerment.
- *Cultural differences.* Additional trust issues may develop stemming from cultural differences between providers – for example, “wounded healers” vs. “professionalized” staff, “expert” role vs. “peer” role, and services within indigenous communities vs. those provided by the dominant culture (Duran, 2006). Many “mainstream” philosophies tend to promote individualism over collectivism, and many Western practitioners embrace a medical model for healing while indigenous cultures may believe that health is attained through the harmony of mind, body and spirit (Comas-Diaz, 2007).
- *Lack of standardized ways to measure outcomes.* Both specialized programs and collaborative efforts can be difficult to measure. Providers are often required to compile data on program outcomes specified by funders or agency mandates.

Recommendations for best practice are limited by the lack of standardized evaluation data across programs, on outcomes of importance to service recipients as well as to providers and funders (Nicholson et. al., 2001).

Erin Patterson-Sexson at S.T.A.R. in Anchorage says insisting that our way of doing things is “better” than what others are doing, or that our priorities are more important, can create barriers to cooperation:

“It is helpful to understand each of us is coming to the table with different agendas, and none of those agendas is designed to hurt the victim. When we come to the table with the attitude that we are the only ones who have the best interest of the victim at heart, then we get ourselves into trouble. It’s easy for us advocates to do that because that’s our job title. But if you look at the forensic nurses, that’s their job title too. They are here to help sexual assault victims. They do have to stay objective, they do have to ask the tough questions. So if we are on a crusade to be the only people in the game to protect victims, then we are going to be in a constant war with all the other disciplines that are trying to do the same thing, only in a different way” (Patterson-Sexson, 2010).

Creating alliances

When working with people impacted by multiple issues, cooperation with other community providers and systems is essential. Cultivating relationships with other providers is well worth the time and effort, according to providers who have been successful in this regard. Paula Lee, Shelter Coordinator at South Peninsula Haven House in Homer, AK, says:

“We’re really connected with all of the services here in Homer. I’ll call Mental Health, and usually they have a waiting list, but if the person is someone we’re serving here, they’ll put them on a priority list for cancellations. We have an independent living center here and if survivors have a disability or are elders, they’re put on a fast track. We also have the homeless prevention project, and if we’re really packed and can’t take a homeless person in, they’ll put them up in a hotel” (Lee, 2010).

Shirley Moses, Shelter Manager at the Alaska Native Women’s Coalition in Fairbanks, AK, describes the partnerships her agency has created:

“We partner with whatever agency or village wants us to go in. I’m also part of the Women’s Community Coalition staff, and we have typically had some money to go and do domestic violence and sexual assault prevention, training and response. Our villages and regional hubs or statewide agencies, Native and non-native, ask us to do trainings. We go in with a lot of prior planning. They self-identify what they want. If they want to focus on domestic violence, we go in and we might have planning meetings with whoever the village identifies as their contact person, talking about what domestic violence issues they have, and then we coordinate with them and set

WHAT DO WE NEED TO KNOW?

Advocates and other service providers cannot be expected to know everything, and we don't need to be an expert on everything. But here's what we do need to know:

- How to recognize signs that a person we are serving may have a problem other than the one we're trained to deal with.
- How to recognize when a person has problems other than the problem they are seeking services or treatment for.
- What resources are available in the community so we can make appropriate referrals.
- How to get word out about our own services so others in the community know we exist and know what we have to offer.
- How to establish working relationships with other providers to ensure a continuum of care.

up a talking group. They identify people they would like to have attend our training, usually three to four days in a location that is agreed upon by everyone that is going to attend. We have gone to small villages. We partner with our public health nurses, our mental health providers. A lot of our villages have mental health advocates. We work with them and their supervisors and their clinicians, the troopers, whoever the village or region or hub identifies as people who can address domestic violence issues. We do the DV 101, usually, and historical trauma, and the effects of domestic violence on children. Then we do brainstorming, break into small groups, and they are the ones who identify strengths, needs, and barriers. And then they try to come up with solutions or ways that they can develop safe homes, what kind of safety net would work in their region or village. They are really creative" (Moses, 2010).

When working with other providers:

- Conduct "trauma-informed" education for both advocates and other providers to increase everyone's knowledge and understanding of the prevalence of trauma, re-traumatization, and coping adaptations (and their negative consequences) by individuals who have experienced trauma. Establish a universal presumption of trauma, recognizing that it could be part of the life experience of anyone with whom we interact (National GAINS Center, 2006).
- All providers need training to recognize co-occurring issues and make appropriate referrals. Agencies can provide education and cross-training in partnership with each

other. Develop community partnerships or work groups to address these issues together. Brown bag lunches and Peer Review while maintaining confidentiality can be helpful.

- Acknowledge controversies rather than pretending they don't exist – “wounded healers” vs. “professionals,” “peers” vs. “experts,” theoretical differences, etc. Training should address dealing with conflict stemming from philosophical differences among multiple helping systems and emphasize the importance of working together for the benefit of individuals who receive our services.
- When encountering providers with different priorities and philosophies, it may help to find areas of agreement first, then work on addressing philosophical differences. Cindy Obtinario, a chemical dependency/domestic violence specialist at New Beginnings in Seattle, WA, finds that it helps to explore the “why” behind the other provider’s philosophy by first asking questions:

“I give them the opportunity to explain their philosophy, and then ask them, ‘Could you consider this?’ And after they’ve had their opportunity to share, then I’ll present mine. I explain that the domestic violence movement is based on empowerment, and we believe that each woman solves her own problems in her own way and time, and each woman is responsible for her own conduct. If you need to monitor progress and conduct in your program, I understand, but that’s not what we do here” (Obtinario, 2010).

A survivor of multi-abuse trauma shares her experience with a helping professional who wasn’t trained about substance use disorders:

“They’d say, ‘You just need to watch your drinking and don’t get so carried away with it.’ Well, that doesn’t work with alcoholism. I kept trying to do it right, I’m telling you! And I tried to ‘do it right’ for years.”

- When seeking to resolve differences, choose your battles. Is the “difference” truly harming someone we serve? Can the providers “agree to disagree” on some issues such as language or terminology?
- Do not imply that other social service providers are bad people, or negligent in some way. They may be unable to provide certain services for valid reasons, such as ethical concerns about providing services beyond their level of expertise.
- Focus on what we can learn from each other. Assume that we can benefit from the other provider’s knowledge as much as they can from ours. As human beings, we tend to be resistant to learning things from people who don’t want to learn from us. That’s just human nature.

- Respect the professional expertise that each party brings to the table. This means sharing what we know and, just as importantly, asking for help and information in areas where our own knowledge base is lacking. For example, most victim's advocates are not experts on mental health care and, conversely, most mental health care providers are not experts on domestic violence. We do not have to be "experts" in each other's fields, but we do need to recognize and capitalize on each other's expertise (Nudelman & Rodriguez Trias, 1999).

- Recognize the limits of each philosophy or theoretical orientation. Karen Foley is a behavioral health specialist and founder of Triple Play Connections, a Seattle-based non-profit organization comprised of mental health, domestic violence, sexual assault and chemical dependency providers working together to cross-train and network in local neighborhoods throughout Washington State. She says:

"I think it's extremely important to look at different approaches for the different issues. For example, I believe that if you try to treat domestic violence through the lens of addiction, using a medical model, you will do a disservice. For example, trying to get someone to accept responsibility for things that are not theirs to own is a form of victim blaming. And the same is true if you try to solely use an empowerment model when somebody is dealing with addiction. Then the provider can miss the boat in being able to help" (Foley, 2010).

- Hold abusers accountable for their behavior and encourage other providers to do so as well. Don't blame victims of domestic violence, sexual assault, stalking or other forms of abuse for the harm that has been done to them or the tools they have used to cope. Remember, in many cases abusers have fostered substance use and created stress and trauma for the people they have hurt and abused.

Types of providers, their philosophies and priorities

Even when priorities and philosophies are different, this doesn't mean we must compromise our own standards to work effectively with others. Nor is it necessary for other providers to compromise their standards or priorities to work effectively with us. When working with other providers, keep in mind:

- Different issues may require different priorities and different approaches. For example, it's perfectly appropriate that an advocate would be focused on safety for victims of violence while a substance abuse counselor focuses on sobriety for people with substance use disorders, a child welfare caseworker focuses on the best interest of children and a criminal justice professional focuses on community safety. Karen Foley of Triple Play Connections says:

"It's really important to learn more about the other issues, and even if you don't agree, to understand why different philosophies and different models are practiced. I've found that the most beneficial thing I can do is listen rather than talk. I've come a long way in understanding that it's really important to look at each issue

separately, and to understand and learn the value of each approach. So when do you use the medical model versus the empowerment model? And when are you looking at a mental health issue versus a chemical dependency issue versus an oppression issue? I think it's very important not to only look through one lens, but to understand the philosophical differences and when you apply them to what issues" (Foley, 2010).

- A key to reconciling differing priorities is to take a *both/and* approach rather than an *either/or* approach, so that priorities and philosophies are not necessarily seen as being in conflict with each other. For example, an advocate's priority of helping a parent get safe from violence is certainly compatible with a child welfare caseworker's priority of protecting the best interest of the children. Karen Foley offers another example:

"The medical model is really, really important when dealing with addictions, because we know that it's a body change, that the body is different in somebody who's addicted or alcoholic versus someone whose body does not respond to alcohol or other drugs in the same way. So there are chemical changes that have happened. It's not about being a bad person. It's about having a bad disease. On the opposite end, when you try to solely use an empowerment-based model on someone who is dealing with the disease of addiction, they don't get help for their addiction, and often end up back in an abusive situation" (Foley, 2010).

A survivor of multi-abuse trauma tells how she benefited from a relationship between a domestic violence agency and a dentist:

"There's a program called Give A Smile Back, and it's pro bono. You had to have damage done to your teeth by domestic violence. They are putting several thousand dollars worth of work in my mouth, and they are giving me my smile back."

- Individual counselors or other professionals within the same discipline may also have differing approaches and philosophies. It may be possible to find professionals in each discipline whose philosophies are compatible with your own. Cultivate relationships with these individuals for the purpose of making referrals.

Here are some examples of types of providers, along with ways to reconcile their philosophies and priorities with your own for the benefit of the people you both serve:

- **Substance abuse counselors.** In recent years, a number of substance abuse counselors have begun moving away from the heavily confrontational approaches that were once popular in treatment centers (Obtinario, 2010). Some counselors employ *motivational interviewing*, an approach which helps people change harmful behavior such as alcohol or drug abuse by exploring and resolving the ambivalence most people feel when they

A WORD ABOUT LANGUAGE

While it's important not to dilute our own message, there are steps we can take to improve communication with other providers across disciplines:

- Avoid jargon. Each discipline has a tendency to create its own brand of alphabet soup. Terms like DART, TRO, OP, MISA, IEP or WRAP may not make sense to people outside your own discipline. If someone else uses acronyms or jargon, don't be afraid to ask what they mean.
- Try to get past "language" differences and listen for the content of what the other person is saying. If you have a preferred term ("program participant" vs. "client," for example), use your own language when talking with other providers, but do not insist that others use it.
- Learning some of the common terms used by other providers – and incorporating some of their language where possible – can aid in building bridges rather than fences. In the Appendix: Definitions, we have included a glossary of terms commonly used by service providers in the various disciplines: victim's advocates, substance abuse counselors, mental health professionals, social workers, and other providers.

seek to make major changes in their lives (Rollnick & Miller, 1995). Emphasis is on respecting individuals' right to make their own decisions as they are ready to do so, which makes the approach compatible with the empowerment approach favored by victims' advocates. Many treatment programs also offer gender-specific programs, which may be more appropriate for women with interpersonal violence issues (IDHS, 2000).

- ***Mental health providers:*** Advocates who work with domestic violence and sexual assault survivors often come from a social justice perspective and employ the *advocacy model*, which emphasizes safety and empowerment, support and access to resources, accountability for abusers and perpetrators, and social change (Warshaw, 2010). Mental health providers, on the other hand, often employ a *clinical model*, which focuses on identifying and relieving symptoms that interfere with an individual's quality of life or ability to function. But Warshaw (2010) points out that common goals of advocates and mental health providers include health, safety, freedom and connection. Also, an increasing number of mental health professionals have recognized the need for *trauma-informed care*, which is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services (Huckshorn, 2004). Develop relationships with mental health providers whose approach emphasizes trauma-informed care, particularly those familiar with and experienced with complex trauma.

- **Disabilities advocates:** Many providers are concerned about the expense that might be involved in making facilities and services accessible to people with disabilities. However, increasing accessibility need not always be an expensive proposition, says Christine King at the University of Alaska Center for Human Development, who has worked in the field of disabilities for more than 18 years. Sometimes improving accessibility may be as simple as relaxing a policy or rule, or giving someone more time to complete a task or goal. King adds that disabilities advocates are eager to offer their assistance to providers with questions about how to make their services more accessible (King, 2009).

- **Indigenous providers:** Differing patterns of caregiving across racial and ethnic groups strongly underscore the need for culturally relevant services (Nicholson et. al., 2001). The dominant culture's social service system tends to promote individualism over collectivism, and many Western practitioners embrace a medical model for healing while indigenous cultures may believe that health is attained through the harmony of mind, body and spirit (Comas-Diaz, 2007). Some advocates and other professionals are uncomfortable with issues of religion and spirituality, while many persons from marginalized groups view adherence to spiritual practices as resilience against adversity (Comas-Diaz, 2007). Advocates should collaborate with indigenous providers, when available. Recognize and enlist the assistance of recognized helpers such as indigenous healers and elders. Also provide cross-training for all providers on diversity issues. Get to know the cultures in your area and invite people from these cultures to provide training for staff.

A survivor of multi-abuse trauma discusses the importance of working with indigenous providers:

“What has been helpful for me is interacting with elders of my village, elders within my region. Elders are individuals with many years of experience. They’re not judgmental or critical. They have big elephant ears ready to listen. I had to go back to my own Alaska Native values.”

- **Child welfare workers:** The number one priority for child welfare workers is to protect the best interests of children who are at risk of harm. Domestic violence increases the risk of child abuse and neglect, especially when substance abuse is involved (IDHS, 2000). Even if they are not intentionally targeted for abuse, children in a home where a parent is being battered are often injured while trying to intervene in a violent incident. And even when children are not physically abused themselves, they still often suffer the traumatic effects stemming from exposure to batterers. Advocates and other providers are mandated to report child abuse and/or neglect to their state's child welfare agency. When child abuse or neglect is suspected, a thorough physical and psychological assessment may also be necessary, as well as other services. Advocates, substance abuse counselors, mental health

professionals and child welfare caseworkers should also collaborate to ensure that children exposed to batterers (and their non-offending parents or caregivers) receive resource information and a safety plan.

- ***Criminal justice personnel:*** When working with a survivor of multi-abuse trauma who is, or has been, incarcerated, keep in mind that preventing recidivism is a priority for most criminal justice professionals. Studies repeatedly show safe housing, employment and appropriate social services are critical to reducing recidivism for these individuals (Covington, 2002). Many survivors suffered traumatic experiences in their lives long before they developed the coping mechanisms that may have led to their incarceration or other involvement with the criminal justice system. Emphasize that helping survivors get the help they need to heal from past abuse or trauma can go a long way toward reducing recidivism.

SELF-CARE AND A HEALTHY WORKPLACE

Supporting people who are survivors of multi-abuse trauma can be immensely rewarding. Providers who do trauma work report appreciating life more fully, taking life more seriously, having a greater scope of understanding of others and themselves, forming new friendships and deeper intimate relationships, and feeling inspired by the daily examples of survivors' courage, determination and hope (Herman, 1997).

However, working with survivors also carries risks for advocates and other providers. Trauma is contagious (Herman, 1997): Because providers bear witness on a daily basis to human cruelty, injustice and the resulting emotional pain, they can become emotionally overwhelmed and may experience to a certain degree the same terror, rage and despair as the people they serve.

Agencies serving survivors of multi-abuse trauma are often under-funded, resulting in chronic understaffing, overly large caseloads and other less than ideal working conditions. Complex issues that challenge the competence of even well-trained and experienced staff can add to feelings of emotional stress. This volatile combination of challenges, if not balanced with an appropriate level of self-care and agency support for staff, can lead to professional burnout and vicarious trauma (Warshaw & Pease, 2010b).

Perlman & Caringi (2009) define vicarious trauma as “the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them.” They differentiate *vicarious trauma*, which refers to “the negative changes that can take place in trauma workers across time,” from *burnout*, which “focuses on the situation, the gap between what the helper is expected to do and what he or she is able to do.”

Despite the contrasts, both vicarious trauma and burnout may result in physical, emotional and behavioral symptoms, work-related issues and interpersonal problems (Trippany, Kress & Wilcoxon, 2004). In addition, both vicarious trauma and burnout are responsible for a decrease in concern and esteem for the people we serve, which often leads to a decline in the quality of care.

Recent research with providers who do trauma work has found responses that parallel victims' and survivors' adaptations, including common post-traumatic symptoms and relational patterns (Perlman & Caringi, 2009). Symptoms of post-traumatic stress such as avoidance, hyperarousal and numbing; relational adaptations such as aggression, reenactments and difficulty with boundary management; as well as general psychological stress have been identified (Warshaw & Pease, 2010b).

This section explores the risk factors for vicarious trauma and burnout, and offers suggestions that can be used on the personal, professional and organizational level to diminish their negative effects.

Impact of vicarious trauma and burnout

Vicarious trauma and burnout can have a damaging impact on both providers and the people they serve. For advocates and other providers, the negative impact can be both personal and professional:

- A provider's work may begin to suffer in a variety of ways: reduced productivity, reduced motivation for the work, lowered self-esteem and sense of competence, increased absenteeism and "sick days" (Warshaw & Pease, 2010b).
- Providers may feel inadequate and question their own abilities to help people (Trippany, Dress & Wilcoxon, 2004). It is not uncommon for even experienced providers to feel suddenly incompetent and hopeless in the face of a traumatized person's complex issues (Herman, 1997).

Shirley Moses, at the Alaska Native Women's Coalition, shares:

"Mentoring people is a big thing for me. ... People don't just look at me now. They look to whoever is with me sometimes, because they are the ones who have taken over that role or responsibility."

- When failing in their intention and commitment to assist the way they think they should, providers may experience guilt and challenges to their worldview, identity, and their own experience of meaning and hope (Perlman & Caringi, 2009). Without a sense of meaning, providers may become cynical, nihilistic, withdrawn, emotionally numb, hopeless and outraged (Trippany, Kress & Wilcoxon, 2004).

- Advocates and other providers may begin to experience work-related intrusive thoughts or

nightmares. They may be left feeling they can't discuss work with family or friends, or conversely, they may find they talk about work all the time and can't seem to escape work-related issues (Warshaw & Pease, 2010b).

- Repeated exposure to stories of human cruelty can heighten providers' sense of personal vulnerability, causing them to become more afraid of other people in general and more distrustful even in close relationships. Providers may find themselves becoming increasingly cynical about the motives of others and pessimistic about the human condition (Herman, 1997).

- Those who experience "witness guilt" or "survivor's guilt" may feel guilty for the fact that they were spared the suffering people they serve have had to endure. This may cause providers to have difficulty enjoying the ordinary comforts and pleasures of their own lives (Herman, 1997).

- If left unaddressed, vicarious trauma can escalate in severity until it meets criteria for a psychiatric diagnosis such as post-traumatic stress disorder, other anxiety disorders, mood disorders, and substance use disorders (Perlman & Caringi, 2009). Providers may also begin to experience health problems – increased illness or fatigue, aches and pains (Warshaw & Pease, 2010b).

When advocates and other providers experience vicarious trauma or burnout, the people they serve suffer in a variety of ways:

- Providers may either avoid discussing traumatic material or be intrusive when exploring traumatic memories by probing for specific details of the individual’s abuse or pushing to identify or confront perpetrators before the person is ready (Trippany, Dress & Wilcoxon, 2004).
- Providers may begin to feel anger or disgust toward the people they serve for not responding to services in some idealized way, and may become extremely judgmental or view certain individuals as “bad victims” (Herman, 1997).
- Providers, like the people they help, may defend against overwhelming feelings by withdrawal or by impulsive, intrusive action. The most common forms of action are rescue attempts, boundary violations and attempts to control the people they serve (Herman, 1997).
- Boundary violations are particularly salient with traumatized people who have already been subjected to violations, exploitation and dual relationships (Perlman & Caringi, 2009).

Risk factors for vicarious trauma and burnout

The complex interaction between traumatized people, stressed staff, pressured organizations, and challenging social, political and economic environments combine to create the perfect conditions for vicarious trauma and burnout (Warshaw & Pease, 2010b). Perlman and Caringi (2009) have identified three major factors contributing to vicarious trauma:

- **Aspects of the work.** Some aspects of working with survivors of multiple traumas increase the likelihood of vicarious trauma in any service provider. Examples include hearing multiple stories of trauma and abuse, having difficulty gaining survivors’ trust, and observing the barriers encountered by people seeking help. When the person seeking help finds it difficult to trust or respect the provider due to past traumatic experiences, or expects to be exploited by the provider in some way, this can challenge the provider’s sense of identity and function. When providers observe the multiple problems experienced by some of the people seeking their help, coupled with the difficulty many survivors have in finding appropriate services in a fragmented system, they may feel like helpless witnesses.

HELP FOR HELPERS

Hearing a traumatized person's story can revive any personal traumatic experiences a service provider may have suffered in the past. Because of this, it is important for providers to acknowledge and heal from their own trauma.

Advocates at Standing Together Against Rape (S.T.A.R.) in Anchorage, AK, have created a support group for service providers who are trauma survivors themselves. The Professionals Group – which has weekly sessions lasting about two hours and runs for about 16 weeks at a time – includes nurses, law enforcement officers, teachers and therapists in addition to advocates. “We’re asking them to come in and push their education aside and talk about their own history,” says Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at S.T.A.R.

She says the Professionals Group originated as a way to address a recurring problem encountered by S.T.A.R. advocates: “We’ve been doing women’s groups for years and years, of course, and we keep having clients coming back to us, saying, ‘I went to this counselor and she didn’t even want to talk about this issue,’ or ‘she made me feel like it wasn’t really that important.’”

Ms. Patterson-Sexson and a therapist colleague speculated that part of the problem was professionals who had their own background of trauma that had not been dealt with or healed. “So let’s get these professionals in here who are dealing with these victims, who aren’t going down this road for one reason or another,” she says. “If it is because they are hung up on their own trauma, let’s start talking about it.”

She says the group may be the first place some participants have been able to talk about their trauma experiences. “So a lot of them are coming in and they are talking about maybe one episode that happened to them in college or in their first marriage

- ***Aspects of the provider.*** Many aspects of advocates or other providers as individuals (personality and temperament, ego resources, coping styles, personal history, support system) and as professionals (level of training and experience with victims of trauma, theoretical orientation and the way one works) may contribute to or protect against experiencing vicarious trauma. Hearing a traumatized person’s story will also revive any personal traumatic experiences the provider may have suffered in the past.
- ***Aspects of the social-cultural environment.*** People with multiple trauma issues are often the most marginalized members of society because of both the stigma of their traumatic experiences and their complex psychological, interpersonal, physical, social, economic and spiritual needs. Many survivors do not have the means for private treatment; thus, they receive treatment in public systems that are notoriously under-

or something that they have clearly identified as, 'This is the event in my life that victimized me.' But as we talk about it and dig into it, they too have had childhood physical, emotional, sexual abuse issues they haven't even named yet. Because they were maybe one of the few to break through and try to stay in school or go to college and get a degree, they had totally detached that trauma from their life. They didn't even own it anymore."

The group is co-facilitated by both an advocate and a therapist. Each weekly session begins with the advocate facilitator introducing a worksheet or topic for discussion. The therapist then takes charge of processing any feelings that come up. "Advocates, historically I think, do a good job of bringing a whole lot of stuff to the surface and acknowledging it and then helping educate," says Ms. Patterson-Sexson. "The therapist is there to help sort all that out and dive into it more."

The professionals group started in February 2010, ran for 16 weeks, broke for a pause over the summer and started again in September. The groups have an average of about nine participants. "We do try to keep the group small, and we have a stricter screening process for that group," says Ms. Patterson-Sexson. "We want to make sure they are in a place where they will really want to share. If they are coming into the group as an educational experience, it is not a fit for them. If the group is another avenue for them to be a provider, then it is not a fit for them."

She hopes the group will have a "positive trickle-down effect" in the helping community. "We want professionals who are listeners all day long. Maybe at the end of the day they are struggling with their own stuff and need some support around it. Who better to support them than a group of colleagues who understand the struggles and the pressure of being a helper?"

Ms. Patterson-Sexson would be glad to talk to people who want to start a similar organization in their communities. (See Appendix: Additional Resources for information on how to contact her.)

resourced. The combination of multiple needs and inadequate resources can contribute to feelings of frustration, helplessness and hopelessness on the part of the advocate or other provider, especially if an individual's traumatic experiences are current and ongoing (for example, homelessness, domestic violence and various forms of re-victimization).

Organizational factors leading to vicarious trauma/burnout

An important factor contributing to vicarious trauma and burnout is the lack of support some agencies provide for services and for staff doing trauma work. The notion of staff care as essential to the well-being of both providers and the people they serve in these settings has only recently emerged (Perlman & Caringi, 2009). Golie Jansen, associate

professor in the Department of Social Work at Eastern Washington University, examined the relationship between perceived organizational support and the levels of vicarious trauma in sexual assault workers. Her research found that when people perceive their organizations to be supportive, they experience lower levels of vicarious trauma (WCSAP, 2004).

The attitude that scarce resources must be directed toward services rather than toward staff support and care may be understandable. However, researchers emphasize self-care is not a luxury but rather is essential, both for the service provider's physical and mental health and for the welfare of the people served by the agency (Perlman & Caringi, 2009). Implications for organizations that don't attend to self-care may include greater use of sick leave, higher turnover, lower morale and lower productivity (Anderson, 2004).

Several organizational practices can be risk factors for vicarious trauma and burnout:

- *Unrealistic expectations.* Vicarious trauma and burnout can occur when advocates and other providers struggle to maintain high levels of empathy and caring in work situations where there is likely to be unrealized and unrealistic expectations (Anderson, 2004). Examples of unrealistic expectations include pressure to accept overly large caseloads or pushing trauma survivors to accomplish goals too quickly.
- *Management style.* “Top-down” management style, in which supervisors question and sometimes invalidate lower-level staff's practice knowledge and self-care attempts, can be particularly disruptive (Perlman & Caringi, 2009). An advocate who has been in the field for several years points out:

“We got hired because they thought we could do the job. When there's competition, or people checking up on each other, or gossip, those kinds of things really tear at the healthy work environment.”
- *Inappropriate demands.* Chronically short-staffed agencies may pressure advocates and other providers to work in ways that mitigate against self-care – for example, working double shifts, or forgoing breaks, comp time and vacation days. Inappropriate multi-tasking demands also contribute to feeling overwhelmed.
- *An abusive workplace where bullying of staff is tolerated.* In a 2007 survey of 7,740 U.S. workers conducted by Zogby International for the Workplace Bullying Institute, 37% reported either being bullied at the present time or at some point in their careers. According to the same survey, 45 percent of targeted individuals suffer stress-related health problems as a result of the abuse. As with other types of violence and abuse in our society, workplace abuse is about the perpetrator's desire to control others (Workplace Bullying Institute, 2010).

Creating a healthy workplace

Organizations have a duty to help reduce the risk of vicarious traumatization in the

workplace by offering an emotionally supportive, physically safe and respectful work environment (Brady, Poelstra & Brokaw, 1999). Here are some ways to ensure a healthy workplace:

- Provide specific training on vicarious trauma and burnout. All staff should be trained about the potential occupational hazards of trauma work and ways to protect themselves, as well as what the organization will do to help minimize the most negative effects (WCSAP, 2004). Training focused on “traumatology” is vital for trauma work and can decrease the impact of vicarious trauma (Trippany, Kress & Wilcoxon, 2004).

An advocate who has been in the field for several years points out:

“We got hired because they thought we could do the job. When there’s competition, or people checking up on each other, or gossip, those kinds of things really tear at the healthy work environment.”

- Address the issue of vicarious trauma and burnout in a nonjudgmental way. Recognize that vicarious trauma is an occupational hazard of trauma work and destigmatize it (Warshaw & Pease, 2010b). Perlman & Caringi (2009) emphasize that neither providers nor the people they serve are to blame for vicarious trauma. Rather, it is a cost of doing trauma work.

- Provide supervision, consultation and plenty of opportunities for debriefing. Staff meetings, supervision and consultation can help people begin to identify ways they are being affected and develop strategies to deal with them, like fostering self-care routines (WCSAP, 2004).

- Pay attention to special training needs. Younger, less experienced workers may need more training since research suggests that they tend to be more vicariously traumatized than more experienced workers (WCSAP, 2004).

- Limit the size of caseloads. Limiting the number of multi-abuse trauma survivors on a staff member’s caseload can help reduce feelings of being overwhelmed (Trippany, Kress & Wilcoxon, 2004). Research shows trauma workers indicate less work-related stress with a moderate number of individuals on a weekly caseload than with higher numbers.

- Create policies that encourage self-care. Policies allowing flexible work schedules and mandating that staff use compensatory and annual leave in a timely manner provide opportunities to rest and to process and integrate the efforts of the work (Perlman & Caringi, 2009). Provide adequate vacation, sick time and personal leave time. Benefits such as paid vacation time and insurance policies covering the cost of counseling are also helpful (Trippany, Kress & Wilcoxon, 2004). Cindy Obtinario of New Beginnings in Seattle, WA, says:

“You need a supervisor who, if you’re not taking care of yourself, instead of saying, ‘Good job for pushing through and filling out all those papers,’ will say, ‘You’ve done a good job and in fact you’re exemplary, but we’re worried about your longevity here because you haven’t taken any vacation. It’s time for you to take some vacation’” (Obtinario, 2010).

- Create a respectful working environment for both staff and the people the agency serves. How staff and supervisors interact with each other models the use of power in relationships. An abusive workplace sends an entirely wrong message. Gene Brodland, a licensed clinical social worker with the Southern Illinois University School of Medicine, says:

“A good work environment will have more leadership than management. The micromanager is watching to catch somebody doing something wrong. The leader tries to catch somebody doing something right” (Brodland, 2010).

Self-care tips for individual staff

Self-care allows providers to protect themselves in ways that enable them to provide better and more effective services to persons with multiple trauma issues. Therefore, Perlman and Caringi (2009) argue self-care is an ethical imperative. Here are some suggestions to help advocates and other providers in this vital area:

- *Social support.* A strong social support network can help prevent vicarious trauma (Trippany, Kress & Wilcoxon, 2004). Connection outside as well as inside the workplace is necessary. Advocates and other providers should develop and maintain sustaining intimate, family and other interpersonal relationships. Wherever possible, they should also disengage from activities and relationships that are depleting and replace them with those that are sustaining (Perlman & Caringi, 2009).

- *Professional support.* This might be a supervisory relationship or a peer support group, and preferably both. The setting must offer permission to express emotional reactions as well as technical or intellectual concerns related to providing services to people with histories of trauma (Herman, 1997). Whereas limits of confidentiality prevent advocates and other providers from being able to debrief with support systems such as family and friends, peer supervision serves as an opportunity to debrief in an ethical manner (Trippany, Kress & Wilcoxon, 2004). In her landmark book *Trauma and Recovery*, Judith Herman, M.D., points out that just as no survivor can recover alone, no provider can work with trauma alone.

- *Opportunities for continuing education and professional growth.* Shirley Moses, Shelter Manager at the Alaska Native Women’s Coalition in Fairbanks, AK, says:

We try to encourage continuing education. We have a graduate student volunteer. We got someone to donate a ticket and per diem and airfare, hotel and everything,

WHAT WE DO TO TAKE CARE OF OURSELVES

In interviews with the authors of this manual, advocates shared what they do to take care of themselves:

“I do a lot of self-care,” says Karen Foley, founder of Triple Play Connections, and a behavioral health specialist and intensive case manager at Pacific Treatment Alternatives in Seattle, WA. “It’s so vital. I practice my faith. I make sure that I put time aside to play. I have a work environment that’s flexible, in that I can use comp time. If I end up in a situation that is really draining one day, I can take the next day off. I also have a lot of vacation time. I have positive co-workers that are really supportive, that I can debrief with at any given moment. The work environment, for it to be healthy, really has to be flexible. Reasonable caseloads are a huge factor too. And occasionally I access therapy.”

“I have to make sure I eat,” says Paula Lee, Shelter Coordinator at South Peninsula Haven House in Homer, AK. “I have to eat my breakfast, and I can’t overload on coffee. I make sure my exercise is in there. And I do my crafts.”

“Self-care is important to me,” says Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at S.T.A.R. in Anchorage, AK. “It might be little things like cleaning off my desk every day before I go home from work, so when I come to work in the morning, I have a fresh slate. Having lotion at my desk or having a little candle on my desk or always having a bunch of gum in my drawer or going out for lunch, getting out of the office. Going to the bookstore. And then, when you need it, take a day off. Don’t wait until you’re ready to quit. Take a day off and get out of the office and don’t answer your cell phone.”

for her to go to a national conference. She is one who will probably give more than she gets at the conference. She is just so excited to be able to attend trainings like that. If people are wanting to be mentors or wanting to become trainers, we give them the chance to grow professionally at their own rate of speed, however they feel comfortable. If they want to do trainings, or participate in the trainings we do, we bring them along. Sometimes at first, we bring them along to give them exposure, and once they feel comfortable, they start chiming in for parts of it, and before you know it, they are up there doing the bulk of that unit of training” (Moses, 2010).

- *Mentoring.* Both new and seasoned staff can benefit from mentoring relationships with people who have experience in the field. Shirley Moses says:

“Mentoring people is a big thing for me. I tell women who work with me, ‘I’m 58 years old. I’d like to sit in a rocking chair on a deck that I want to build in my spare time someday. I want you guys to feel comfortable and recognize your strengths,

where you can take over.’ We have the SART meetings, and I really want my advocates with me on a regular basis. One of them goes to the domestic violence task force meetings with me. At first they sat, and I was the vocal one and now they are becoming the vocal ones in that venue, and they are getting recognized. People don’t just look at me now. They look to whoever is with me sometimes, because they are the ones who have taken over that role or responsibility” (Moses, 2010).

- *Consultation or counseling.* Professional consultation or counseling allows advocates and other providers to acknowledge and reflect on their reactions to the intense feelings and extreme behaviors sometimes exhibited by survivors of multi-abuse trauma. Examining personal responses in a supportive, confidential, trauma-informed, professional counseling relationship can be a powerful source of support in identifying and managing vicarious trauma (Perlman & Caringi, 2009). “The healer needs to have someone for support in that area, so that they make sure they stay current with their own issues, and for processing issues that present themselves about the work,” says Cindy Obtinario of New Beginnings in Seattle.
- *Realistic expectations.* Focus on process rather than outcomes. For many survivors, especially those with multiple trauma issues, healing is a long, slow process. A focus on doing what needs to be done rather than on an individual’s ability to live differently, will likely result in less frustration for both providers and the people they serve. Realize that even the most competent providers cannot accomplish miracles. They can neither undo the past nor protect people from all future harm (Perlman & Caringi, 2009). Also have realistic expectations for yourself, in terms of the workload you are capable of handling.
- *Boundary management.* Set clear boundaries between home and work. Managing boundaries appropriately includes remembering the provider’s role and mandate, treating the people one serves with respect and leaving work at the office (Perlman & Caringi, 2009). Paula Lee, Shelter Coordinator at South Peninsula Haven House in Homer, AK., says:

“I constantly tell people, ‘It’s good to feel compassion. But let the problems leave when the people leave your bubble. Don’t take on everybody’s stuff.’ That is a healthy boundary. I don’t take the women in the shelter or the staff everywhere I go.”

People who last longer as advocates and helping professionals generally develop a system of closure. Long-term advocates report numerous coping strategies such as saying a prayer at the end of the day, changing clothes, placing a rock in a garden, lighting a candle, taking a walk, a bath, or a steam when they are ready to move from the work setting to their personal space. The method of closure is less important than the purpose it serves. Advocates with good boundaries are able to let go at the end of a day, acknowledge they have done what they can and let go long enough to actively engage in their own lives. This balanced approach fosters good health and makes it possible for advocates and other providers to continue doing their work just for today, one day at a time.

- *Respite and replenishment.* Create frequent opportunities to engage in activities offering distraction and/or personal growth, to exercise, have fun, rest, relax and connect with others. Physical activities during breaks at work such as stretching, taking a walk and exercising may provide an antidote to ongoing bodily tension and may further counter the sedentary nature of many work settings (Perlman & Caringi, 2009).

- *Spiritual renewal.* Given the central role of spirituality or meaning systems to trauma, it is essential to attend to the development of whatever is self-nourishing, whether that be traditional practices such as prayer and organized religion, or being useful to others, or enjoying nature (Perlman & Caringi, 2009). Participate in activities designed to increase your personal tolerance level. Including journaling, personal counseling, meditation, and obtaining emotional support from significant others allows reconnection to emotions (Trippany, Kress & Wilcoxon, 2004).

- *Social activism.* Advocates and other providers angry about injustices – ranging from perpetrator behavior to lack of appropriate funding levels for social service agencies, statements made by judges or defense attorneys, and societal attitudes toward victims – may find social activism is a way to channel their feelings in a productive and constructive manner (Wasco & Campbell, 2002).

- *Balance.* Confronted with the daily reality of people in need of care, advocates and other providers are in constant danger of professional over-commitment. Providers must understand their own realistic limits and strive to take as good care of themselves as they do of others. Providers have many strengths and resources they use to help traumatized people. Helping themselves, as well, serves both their own interests and the best interests of the people they serve (Herman, 1997).

Paula Lee, at South Peninsula Haven House, shares:

“It’s good to feel compassion. But let the problems leave when the people leave your bubble. Don’t take on everybody’s stuff. That is a healthy boundary. I don’t take the women in the shelter or the staff everywhere I go.”

“My brain says I can do all kinds of things,” says Cindy Obtinario of New Beginnings in Seattle. Only half jokingly, she adds, “And my body says, ‘What? Are you kidding?’” Balance also includes the development of healthy habits. Getting sleep and good nutrition can reduce the toll stress places on the body. While nicotine can act as an anti-hostility agent and alcohol and other drugs can initially provide relaxation, energy or escape, reliance on these substances can pose health dangers and other risks for advocates and other providers.

The Alaska Network on Domestic Violence Training Project encourages advocates to

consider alternatives to alcohol and other drug use following exposure to trauma and stressful events. We recommend debriefing following a stressful incident within 24 hours, preferably before sleep. Sharing feelings, rather than confidential details, with another trusted human being as soon as possible is critical. It is also helpful to refrain from substance use (including alcohol) for at least 72 hours (or longer) following a traumatic incident whenever possible. These choices can facilitate the internal processing of a traumatic event and serve as psychological first-aid reducing the likelihood of long-term mental health consequences.

Finally, remind yourself that you really are making a difference in people's lives. "You don't always know you're helping when you're helping, because they don't always tell you," says Olga Trujillo, Director of Programs at Casa de Esperanza in St. Paul, MN. "So just hold onto that, that you can make a huge difference in people's lives and you do make a difference" (Trujillo, 2009).



ADVOCATE TOOL KIT

ASSESSING NEEDS

While it is not necessary for advocates to become substance abuse counselors or mental health professionals, it *is* important to ask about co-occurring issues people we serve may be experiencing to ensure we are able to accommodate their needs.

However, timing is important. The intake and screening process for admitting people into your program should come first. Assess for co-occurring issues only *after* an individual has been admitted. Questions about co-occurring issues should *never* be part of the screening process. This section contains some helpful tips to make the intake and assessment process less painful, for both staff and the people you serve.

Reducing intake trauma

Most of our programs require that people receiving services complete an intake process. All intakes have a common thread, say Sonia D. Ferencik & Rachel Ramirez-Hammond in *Trauma Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs*:

“Intakes inquire about extensive, detailed, personal information on a subject that is very sensitive for most individuals. Some survivors find this process extremely painful, and there are many opportunities to trigger an individual or retraumatize someone seeking services.”

In their manual, Ferencik & Ramirez-Hammon (2011) offer several suggestions for making the intake process less stressful and intimidating for the people you serve:

- Before you begin, describe what will occur during the intake process and why you need the information. Reassure individuals that they have the right to “put on the brakes” by asking to stop the process if any of the questions cause them to become triggered, exhausted or in need of a physical or emotional break.
- Inform individuals what you are writing down and why you are documenting what is shared with you. Also fully explain the release of information form and any other documents you are asking them to sign, and offer them plenty of time to read documents if they desire to do so before signing.
- Explain the limits of your confidentiality before you begin, since this may impact which issues an individual feels safe sharing with you. Clarify to survivors what information you cannot keep confidential due to ethical, professional, or legal obligations. This often includes information about imminent harm to a child or credible threats to hurt another individual or oneself.

- Intake questions are often shaped around grant reporting requirements and require lots of information that may seem unnecessary and even insensitive to a survivor in crisis. Remember this and have empathy for the feelings survivors have about the process.
- Include survivors in deciding when to complete their intake. Individuals may feel much better about answering needed questions once they have had a chance to get themselves and/or children settled.
- Pay attention to the environment. Is the space where you are doing the intake interview quiet and private, or are you constantly interrupted by others or have people passing by in the background? Do you have tissues and water available? Allow the individual to modify the lighting and perhaps even offer quiet music as an option. Offering water, tea or coffee and a choice of snacks during the intake can also help put the individual at ease.
- When concluding the intake process, ask how the individual is feeling. Make sure you are not letting the person leave feeling vulnerable. Questions to check out include: How are they feeling both physically and emotionally? Do they have any questions they wanted to ask?

(See our Appendix: Additional Resources, for information about the manual *Trauma Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs*, and how to get a copy.)

Performing a needs assessment

A needs assessment can be a nonthreatening way to glean information about co-occurring issues that may need intervention or referrals. The goal of a needs assessment is to ascertain ways your program can better serve an individual rather than to screen a person in or out of the program. When conducting the assessment:

- The needs assessment should be done *after* individuals have been admitted to your program. Emphasize that the assessment will have no impact on shelter status or ability to stay in the program.
- “Normalize” questions and find a way to discuss co-occurring issues that is comfortable for both of you. “Normalize” responses to traumatic situations, rather than pathologizing the individual (Ferencik & Ramirez-Hammon, 2011).
- Allow people who seek our services to tell us what they need and when, rather than assuming the “expert” role and telling them what they need. “When you’re working with people, allow them to take the lead,” says Olga Trujillo, Director of Programs at Casa de Esperanza in St. Paul, MN. “So when they come to you, they might be in a place to be able to deal with a certain issue, or they may not be in a place to be able to deal with it. They might just need crisis management. Or they might need something more than that. And they’re going to let you know” (Trujillo, 2009).

- Ensure that people impacted by both interpersonal violence and co-occurring issues know about available resources. Explore options such as transitional housing, counseling, gender specific substance abuse treatment, support groups addressing multiple problems, children’s services, safety planning and linkage to other providers.
- If lack of appropriate training or credentials prevents you from answering a question or providing a certain kind of assistance, explain this to the individual seeking your help. Make it clear you will help them figure out who can provide the needed help and are happy to explore options with them.
- Use an interpreter when necessary. However, avoid using children, relatives of the abuser or people who do not understand confidentiality and domestic violence, sexual abuse and stalking issues.
- An individual’s decision to decline treatment, advocacy, shelter or other services should not be viewed as failure. Supporting people through their process of change requires an understanding that motivation comes from within. Making changes is both an option and a process that can take time.
- Understand the courage required to seek services. Convey to the people you serve that you appreciate their courage: “With all the stuff that’s going on for you, you still managed to do this. That’s fantastic” (Obtinario, 2010).

How do we ask those “sticky” questions?

Advocates and other providers are sometimes reluctant to ask about certain issues, lest they offend the people who come to them for help. Substance abuse may feel like a particularly touchy topic – especially if activities such as sex trafficking or illegal drug use are involved. Asking about mental health concerns or suicide risk may also feel tricky, and providers may fear risking legal problems if they ask about disability issues.

However, advocates may miss countless intervention opportunities if they are afraid to ask the important questions (Bland, 2001). And asking the right questions can even be life-saving. For example, advocates should always assess for suicide risk or potential for other self-harm (Pease, 2010).

The intervention is in the asking (Bland, 2001). Fortunately, there are respectful ways to raise sticky issues. *Please note: These questions should NEVER be part of the initial screening process. Only ask these questions AFTER the decision has been made to admit a person into your program.*

Regarding substance abuse, Cindy Obtinorio, a chemical dependency/domestic violence specialist with New Beginnings in Seattle, WA, says: “The way we frame this questioning process is, ‘We are asking for this information not to screen you out, but to help support you in seeking safety, and to be able to give you the best referrals possible’” (Obtinario, 2010).

Individuals may find it easier to talk about stress in their relationships or their partner's substance use or mental health *before* talking about domestic violence, sexual assault, their own substance use, mental health concerns or other personal issues. Asking open-ended questions can be helpful:

“What has worked well for you and what has given you problems?”

“Many people tell me a little alcohol helps take the edge off stress. How often has this worked for you?”

As another example, Farley (2003) stresses the need for questions regarding a history of exploitation by the sex industry. Unless screening questions such as these are asked, she says, this type of victimization will remain invisible. Questions she suggests include:

“Have you ever exchanged sex for money or clothes, food, housing, or drugs?”

“Have you ever worked in the commercial sex industry: for example, dancing, escort, massage, prostitution, pornography, phone sex?”

While asking people with disabilities a question such as “Do you have special needs we should be aware of?” may feel disempowering, a more general question would be appropriate to ask *anyone* seeking services, whether they have a disability or not (Leal-Covey, 2011). Examples of general questions would include:

“Would you let me know if you need anything?”

“Please feel comfortable asking if you need anything.”

If the individual has been a target for oppression due to misconceptions about race, culture, sexual orientation, disability or other status, consider how these other oppressions impact the experience of trauma and access to services. Also consider how the individual's cultural background may have been a source of support. Questions suggested by Ferencik & Ramirez-Hammond (2011) include:

“What has worked for you in the past?”

“What has helped you within your culture and family of origin?”

Here are some additional examples of questions you can ask to better accommodate individuals participating in your program.

Sample framing questions about abuse:

“Women often report feeling stress in their relationship. How does your partner show disapproval?”

“Please describe any threats made by your partner. (How often? When was the last time? Were you afraid? Were you hurt? Can you tell me what happened?)”

Sample framing statements:

“Domestic violence and sexual assault are major problems for women. Because abuse is such a common experience for women, I ask everyone I see whether they feel safe.”

“Women in treatment often tell me their partners complain about their using. How does your partner show disapproval?”

Sample indirect questions:

“You mentioned your partner loses his temper with the kids. Can you tell me more about that? Have you ever felt afraid for yourself or your children? Can you tell me more about that?”

“All couples argue sometimes. Does your partner’s physical or sexual behavior ever frighten you?”

Sample questions if partner is user or abuser:

“Many women tell me their partners don’t want to *drink/drug/smoke* alone. How often do you find yourself using when you don’t really want to?”

“When a partner spends family money on drug use, it is a form of economic abuse. Has your partner ever used food or rent money to drink or score drugs?”

Sample framing questions for substance abuse:

“Women I see often tell me they feel stress. There are several ways to deal with stress. What works best for you?”

“Many women tell me they try to sleep more, eat better or shop for baby things. Have you tried any of those ways of coping?”

“Many women also tell me the best way to cope is to smoke a cigarette, have a drink or take something else. How often has that worked for you? Do you find it is still working?”

“Being involved in a *court case/custody dispute* can be stressful. Your partner may attempt to undermine *you/your parenting skills*. Can you identify any reasons why drinking or using drugs right now could be harmful to your case? Can you share with me what your partner might say about your drinking or drug use?”

Remember to ask direct questions tactfully and respectfully! These questions may help

advocates and other providers identify accommodation needs for individuals using services. Answers to these questions are **NOT** used to screen people out. They are provided to help survivors address safety or health risks stemming from multiple abuse issues.

While advocates and other providers may hesitate to ask “taboo” questions because they fear giving offense, for many people seeking help, these same questions can send a positive message:

“It’s safe to talk about this issue here.”

When people are respectfully asked about substance use, mental health concerns and other issues that may impact their safety, they hear your message, even if they are not ready to enact change immediately. Often individuals will later share comments such as, “You know, when you said ____, it really made sense to me” (Bland, 2001).

Follow-up questions to enhance service provision for all

Following in this section is *Where Can I Get Help?* – a comprehensive needs assessment form that can help advocates and the people you serve to assess what kinds of assistance and referrals are wanted or needed. Also included are some questionnaires designed to provide further assistance in assessing needs – *Emotional Well-Being: Sample Questions to Ensure Better Accommodation*, *CAGE Questions*, and *The 4 P’s*. Use these questionnaires to assess needs **ONLY**, not to screen people in or out of your program.

When using these forms and questionnaires, keep in mind:

- Information derived using these tools should **not** be placed in an individual’s file due to the sensitive nature of the information to be discussed and confidentiality concerns.
- Do not make assumptions about the people you serve. These questions should be addressed with *everyone*, to determine how we can best accommodate them.
- These tools should *never* be used as screening tools at intake. Using these tools to withhold services – that is, to screen people out – would be a violation of both the Americans with Disabilities Act and Fair Housing regulations.
- Once needs have been determined, give the *Where Can I Get Help?* form to the individual with the appropriate referrals and contact information filled in.
- If your agency offers support groups, you may wish to use the *Where Can I Get Help?* form as the basis for a general group discussion of resources available in the community. The group facilitator might ask, “Where would a person go who needs rental assistance?” “Where would someone go who needs a bus pass?” And so on. Then have the group fill out the form as a group activity.

Where Can I Get Help?

Please let us know what advocacy or assistance we can provide for you or your children to better accommodate your needs while you are receiving services from us.

Social Security card, birth certificate, other I.D.

Agency _____ Phone: _____

Address: _____

Advocacy/counseling for domestic violence

Agency _____ Phone: _____

Address: _____

Advocacy/counseling for sexual assault

Agency _____ Phone: _____

Address: _____

Advocacy/counseling for past sexual abuse issues

Agency _____ Phone: _____

Address: _____

Housing/rental assistance

Agency _____ Phone: _____

Address: _____

Utilities

Agency _____ Phone: _____

Address: _____

Furnishings for home

Agency _____ Phone: _____

Address: _____

Phone/phone card

Agency _____ Phone: _____

Address: _____

Food/food stamps

Agency _____ Phone: _____

Address: _____

Grooming supplies

Agency _____ Phone: _____

Address: _____

Clothing

Agency _____ Phone: _____

Address: _____

Transportation/bus pass

Agency _____ Phone: _____

Address: _____

Medical/dental care

Agency _____ Phone: _____

Address: _____

Prescriptions/medication

Agency _____ Phone: _____

Address: _____

Mental health care

Agency _____ Phone: _____

Address: _____

-

Substance abuse treatment

Agency _____ Phone: _____

Address: _____

Community support group referral

Agency _____ Phone: _____

Address: _____

Counseling for children/significant others

Agency _____ Phone: _____

Address: _____

Support for disability issues

Agency _____ Phone: _____

Address: _____

Pregnancy/Sexually Transmitted Infections Testing/Screening/Services

Agency _____ Phone: _____

Address: _____

Employment assistance

Agency _____ Phone: _____

Address: _____

Child care

Agency _____ Phone: _____

Address: _____

Education/training

Agency _____ Phone: _____

Address: _____

Legal assistance

Agency _____ Phone: _____

Address: _____

Spiritual needs (including rides to church, etc.)

Agency _____ Phone: _____

Address: _____

Other: _____

Agency _____ Phone: _____

Address: _____

Other: _____

Agency _____ Phone: _____

Address: _____

Emotional Well-Being: Sample Questions to Ensure Better Accommodation

To better accommodate an individual's needs the following questions can be asked *following* intake to provide information about how staff can best respond when a survivor is having an emotional crisis:

- What are situations that are particularly difficult for you or make you feel unsafe or upset (*i.e., noise, not being listened to, loneliness, being teased, contact with family, being alone, laughter, yelling, crying, being touched, time of year, time of day, particular dates/holidays, certain words, crowds, malls, bus stops, doors open/closed, smells, sounds, contact with certain people, etc.*)?
- What signs do you notice when you are beginning to feel stressed and out of control (*sweating, breathing hard, sleeping a lot, restlessness, crying, avoiding people, feeling hyperactive, eating more, eating less, etc.*)?
- If you are anxious or angry and those feelings are getting so intense they may be impacting your safety or another person's safety, how would you prefer that staff members assist you?
- What has been particularly helpful to you in the past when you had a difficult time with your thoughts and/or feelings (*such as more time in a quiet area, physical exercise, talking to a friend or family member, taking a bath or shower, meditation, reading, leaving the room, listening to music, journaling, reading, medication, etc.*)?
- What has not been particularly helpful to you in the past when you had a difficult time (*such as being asked to stay in a room, not being taken seriously, noisy environment, etc.*)?
- Is there a person who has been helpful to you when you were overwhelmed or distressed? Would you like to call that person if you get distressed here? Do you have that telephone number? Would you give us written consent to call this person if you are in great distress and we cannot seem to help?
- Have you noticed any triggers that you associate with being anxious or angry? If so, what are these triggers?
- Do you have coping strategies to deal with difficult memories? Group living can trigger difficult memories especially if you were ever hospitalized for mental illness or have been in treatment for substance addiction. Are there any situations that might trigger difficult memories for you here? Let us know if there are ways we can offer emotional support to you during your stay.*
- *If room checks are part of the routine at the shelter:* Is there anything we can do to make the room checks comfortable for you?

- If you are taking medications and have concerns about them during your stay please let us know. Sometimes an abusive partner controls medication. An abusive partner may tamper with meds, steal meds or withhold meds. If you take any medications, need them and were not able to bring them with you to shelter, let us know. We can provide you with information and referrals or advocacy to better accommodate you during your stay. Please also advise us if you think your medication(s) is not working effectively for you or if there are any side effects from the medication(s) that we should know about to better support you during your stay. If you need or have reminders to keep your medication schedule let us know how we can help you.*

Reprinted by permission from *Beyond Labels: Working with Abuse Survivors with Mental Illness Symptoms or Substance Abuse Issues* by Dianne King Akers, M.Ed., Michelle Schwartz, M.A., and Wendie H. Abramson, LMSW. Adapted from Carmen, E., et. al. (1996, January 25). *Task force on the restraint and seclusion of persons who have been physically or sexually abused: Report and recommendations*. Massachusetts Department of Mental Health. (Note: materials noted with an *adapted by P. Bland, 2008).

CAGE QUESTIONS

CAGE-AID QUESTIONS

1. Have you ever felt you ought to cut down or stop using alcohol or other drugs? (Cut down.)
2. Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs? (Annoyed.)
3. Have you felt guilty or bad about how much you drink or use? (Guilty.)
4. Have you been waking up wanting to have an alcoholic drink or use drugs? (Eye-Opener)

CAGE-DV

1. Have you ever felt Controlled or threatened by your partner?
2. Has anyone Annoyed you or gotten on your nerves by expressing concern about your partner's behavior towards you?
3. Have you felt Guilty or bad about how your partner treats you?
4. How often do you wake up anxious, afraid or wanting to Escape your partner?

Remember to ask direct questions tactfully and respectfully!

*These questions may help advocates and other providers identify accommodation needs for people using services. Answers to these questions are **NOT** used to screen people out. They are provided to help advocates assist individuals addressing safety or health risks stemming from multiple abuse issues. To ensure confidentiality, do not include answers to these or other assessment questions in an individual's file.*

Adapted by P. Bland from J.A. Ewing (1984). "Detecting Alcoholism: The CAGE Questionnaire," *Journal of the American Medical Association* 252: 1905-1907.

THE 4 P'S

4 P's for Substance Abuse

1. Have you ever used drugs or alcohol during **P**regnancy?
2. Have you had a problem with drugs or alcohol in the **P**ast?
3. Does your **P**artner have a problem with drugs or alcohol?
4. Do you consider one of your **P**arents to be an addict or alcoholic?

Ewing H. Medical Director, Born Free Project. Contra Costa County, 111 Allen Street, Martinez, CA 94553.
Phone: (510) 646-1165.

4 P's for Domestic Violence

1. Have you ever been hit or hurt by your partner during **P**regnancy?
2. Has your (*current or former*) partner been violent or abusive in the **P**ast?
3. Does your (*current or former*) **P**artner have a problem with violence or abuse now?
4. Do you consider one of your **P**arents to be violent or abusive?

Adapted by P. Bland from the 4 P's alcohol and other drug screening tool developed by H. Ewing, Medical Director, Born Free Project.

Remember to ask direct questions tactfully and respectfully!

*These questions may help advocates and other providers identify accommodation needs for people using services. Answers to these questions are **NOT** used to screen people out. They are provided to help advocates assist individuals addressing safety or health risks stemming from multiple abuse issues. To ensure confidentiality, do not include answers to these or other assessment questions in an individual's file.*

TRAINING PROVIDERS

Interdisciplinary cross-training for advocates and community partners is essential for the kind of cooperation needed to provide adequate services to people impacted by multiple issues. Target audiences for cross-training include substance abuse treatment providers, mental health providers, disabilities advocates, law enforcement and other criminal justice personnel, child welfare caseworkers, private practice therapists and counselors, health care providers and staff at public health organizations.

Training providers in other agencies can go a long way toward helping victims of violence get their needs taken seriously, no matter where they enter the system. Shirley Moses, Shelter Manager at the Alaska Native Women's Coalition in Fairbanks, AK, says:

“I think that's one thing that has come up time and time again in the different trainings and the different listening sessions we have had, both with providers and women and extended family who deal with our women who come into shelter. Be open to hearing her story. Have her first responder, or her intake people trained to recognize basic domestic violence and sexual assault as being triggers for her other issues. If they see someone who is acting depressed or whatever, not to discount them as being mentally ill or having alcoholism and that being the only thing they focus on. To look at maybe having their intake people, especially their rural social workers, trained in domestic violence and sexual assault” (Moses, 2010).

This section offers ideas for providing cross-training on limited budgets, general training guidelines, tips for effective presentations, and sample training topics.

Training on a budget

Despite the tight budgets, staffing shortages and scarce resources many agencies have to work with, a little creativity can work wonders to expand training opportunities:

- Think outside the box. Training need not be limited to large conferences or seminars. Small in-house workshops, brown bag lunches and Peer Review while maintaining confidentiality can also be helpful. Continuum of care groups, community providers' councils and consortiums can allot 15-20 minute time slots for member agencies to give short presentations about their issues and services.
- Create work groups to address training issues together. Sharing staff expertise is a very low-cost way to provide cross-training. Domestic violence/sexual assault programs, Tribal organizations, mental health programs, substance abuse treatment centers, criminal justice organizations and other providers can lend their own staff to provide in-house cross-training for the staff at each others' agencies.

- Collaborate with Tribal, State and other community partners for larger events. Several agencies can pool their financial resources and staff, and work together on all phases of the planning for large conferences and seminars, thus reducing the burden on each individual program.
- Seek sponsors. Solicit local businesses or organizations to sponsor training conferences or seminars. This can be a win-win situation in which the business gets a promotion opportunity and the agency gets extra funding for the event. Ways to recognize sponsors include space for a display table, listing on conference literature and announcements during the conference thanking the sponsors.
- Don't limit requests to funding. Business or organizational sponsors may be able to provide in-kind donations as well. These can range from free or reduced-rate meeting space to printing or copying, and refreshments.

Paula Lee, Shelter Coordinator at South Peninsula Haven House in Homer, AK, says her agency frequently invites staff from other agencies to give in-house presentations:

“We'll have them come in every year or so, or maybe twice a year, if the need is there, and have them explain their program. Then the advocates get to learn.”

Guidelines for organizing and conducting training sessions

Whether you're conducting a small in-house gathering or a larger event, here are some ideas to help you attract participants and make them comfortable:

- Choose the location carefully. The room should be large enough to comfortably accommodate tables, displays and equipment as well as all the people, but should not dwarf the crowd.
- Provide food and drinks. Coffee, tea, water, healthy snacks and traditional foods add a nice touch, even for small in-house training sessions.
- Provide good handouts. Consider creating a packet for each participant. Items to go into the packet may include one-page fact sheets, a printout of any PowerPoint presentations, a brochure about your agency or service, a business card or contact information for each speaker, and an evaluation form. Packets need not be elaborate – photocopies and inexpensive folders work fine.
- If possible, offer continuing education credits (CEU's) that various providers can use to meet their licensing and/or certification requirements. This can be an important draw if you want to attract as many people as possible to your training sessions.

Preparation for trainings and presentations

Most public speaking pros will agree: The first, and most important, key to an effective presentation is adequate preparation. Start by asking yourself what you want your audience to take with them when they leave. What are the main points you want to make? Use these to create an outline.

You will want to pay particular attention to your introduction and your conclusion. The introduction is your “first impression” for your audience; it should get their attention and interest, reveal the topic of your presentation and establish credibility (why the audience should listen to you). An effective conclusion will signal the end of the presentation, reinforce your message and provide a sense of closure.

Here are some more pointers for the preparation stage:

- If you’re having trouble coming up with an outline, try writing your conclusion or summary first. It should emphasize the most important points you plan to make. Once you have visualized these points, it should be easier to build a presentation around them.
- Prepare note cards summarizing your major points. But use your notes sparingly. Avoid the temptation to write out your entire presentation beforehand, or you will invariably give in to the further temptation to read your presentation.
- Start your preparation early. If you’re like most people, you’ll probably be making small changes right up until you walk to the front of the room, but don’t wait till the very last minute to start planning your presentation.
- Practice, practice, practice. Rehearse your entire presentation out loud at least once before you get up in front of your audience, even if your “practice” audience is only your partner, your best friend or your cat.
- On the other hand, don’t memorize. Rehearsing is one thing; committing the entire presentation to memory and performing it by heart is another. You need to present, not recite.
- Choose your outfit with care. You will want to dress professionally but comfortably. This is not the time to break in a scratchy new suit or tight new shoes.

Visual aids

While effective presentations do not require visual aids, a few well placed visuals can add clarity and impact. For example, statistical information is easier for your audience to understand when presented visually through charts and graphs. More importantly, visuals can also help your audience stay focused and retain information. Examples of visual aids

include posters, overheads, PowerPoint slides, computer graphics, videos and actual objects. Here are some suggestions for using visual elements effectively:

- Keep it simple. A simple visual aid used well is much more effective than a complex one used poorly.
- New technology is wonderful, but don't break in new equipment 15 minutes before the presentation starts. And whatever you do, don't have rented equipment scheduled to arrive 10 minutes before you speak. Check out everything in advance.
- Visuals should add to the presentation, not distract from it. Make sure your presentation has enough substance to equal your visuals so the audience focuses on your message. When the session is over, you want the audience discussing your ideas, not the special effects.
- Make sure your visuals are clearly visible to the entire audience. Everyone, including those in the back of the room, must be able to see, read and understand each visual.
- Speak to your audience, not your PowerPoint. Avoid the temptation to constantly look at or read from your PowerPoint script.
- Avoid distributing objects or handouts during your presentation. This distracts the audience and reduces their attentiveness. Distribute handouts either before you begin, or at the end of your presentation. One advantage of distributing handouts beforehand is that people will know they're getting a printout of your PowerPoint presentation, and they will listen to you rather than feeling the need to furiously jot down notes.
- Rehearsing includes the entire presentation. If you will be using visuals, rehearse these along with the spoken portion of your presentation.
- Be prepared for disaster. Projector bulbs can burn out unexpectedly, posters can fall down and videos can jam in the machine. Always prepare an alternate plan so you do not have to depend on your visuals or other props to carry the presentation.
- Remember that visuals can only add to a good presentation; they cannot rescue a poorly developed one. Do not put all your time and effort into your visuals at the risk of ignoring adequate preparation of the message itself.

Engaging your audience

The good news is, most people come to a training seminar or workshop prepared to have a profitable experience and learn something, and they bring with them a great deal of goodwill toward those they listen to. So relax, and follow these suggestions when giving a presentation:

- Begin with a smile. This conveys to the audience that you are well prepared and have something worthwhile to say.
- Pick one or two people easily visible to you and “speak” to them. This will help you keep in touch with your audience minus the panic that can set in if you’re focusing on a whole sea of people. If some people in the audience seem especially attentive, focus on them. Your audience won’t know the difference.
- Keep it brief. The proper length of your presentation will depend on the subject, but don’t feel you need to ramble to fill in “space.”
- Keep an eye on how well your audience is following your presentation. Are they attentive? What about body language? Are they fidgeting or checking their watches? Taking naps? (Snoring is a bad sign.) If the audience seems distracted, you may need to pick up the pace a bit.
- In your conclusion, call for definite action on the part of your audience. Give concrete suggestions on what they can do to support your ideas or learn more about the subject.
- Leave time for a question and answer period. This allows you to provide more details or clarify major points in a setting with high audience attention.

Sample training topics and handouts

Here are some sample topics for use in training advocates and other community providers, along with suggestions for handouts to use with each topic. These are examples only! Nothing here is carved in stone – feel free to be creative with these topics and come up with some of your own.

Note about copyright: People facilitating trainings are free to photocopy as many of the handouts as they wish for educational use. However, please make sure the copyright notices appear on each of the handouts. We also request that the handouts not be altered in any way, especially the Power and Control Wheels. Please note that the Power and Control Wheels appear here courtesy of the National Center on Domestic and Sexual Violence, which credits the Domestic Abuse Intervention Project in Duluth, MN, for inspiring the wheels.

Topic: Brown Bag Series – Issues 101

Invite community programs to provide in-house cross-training for the staff at each others’ agencies. Experts may include advocates from domestic violence and sexual assault programs, mental health providers, substance abuse treatment counselors, child welfare caseworkers, indigenous providers or anyone else with expertise that you want to learn from. The cross-trainings could be provided as a series: Domestic Violence 101, Sexual

Assault 101, Substance Abuse 101, Mandated Reporting 101, Historical Trauma 101, etc. Add a sweetener to this series by arranging for continuing education credits (CEU's) to be offered to staff in attendance at the various agencies.

Topic: Multiple Layers of Trauma

Explain the concept of multi-abuse trauma. Give examples of *active abuse* and *coping abuse*, and discuss how these different forms of abuse interact with each other to make safety, sobriety and wellness more difficult to achieve. Explain how co-occurring issues such as psychiatric illness, disabilities, social oppression, poverty and homelessness can complicate the picture, and discuss ways the social service system can avoid further traumatizing individuals.

Handouts

Multiple Layers of Trauma

Trauma: The Common Denominator

Multi-Abuse Trauma Graphic

1+1=10 Tons of Trouble

Other Issues: What Else Impacts Safety and Sobriety?

Instruction Sheet for 10 Tons of Trouble Exercise

Abuses Endured by a Woman During Her Life Cycle (Wheel)

The various Power and Control Wheels can also be helpful in illustrating the abuses of power involved in multi-abuse trauma.

Topic: Examples of Abuse

Discuss the different types of abuse that can happen to people with multi-abuse trauma issues. Examples include domestic violence, sexual assault, child abuse, societal abuse and oppression based on misperceptions about gender, race or ethnic group, disability status, sexual orientation, etc. Explore common elements of these different types of abuse. Examples of common elements may include physical abuse, psychological abuse, sexual abuse, spiritual abuse, economic abuse, use of privilege by a dominant group, etc.

Handouts

Examples of abuse

Manifestations of Violence

Power and Control Wheel for Women's Substance Abuse

Lesbian/Gay Power and Control Wheel

People with Disabilities and Their Caregivers: Power and Control

Violence Against Native Women

Immigrant Power and Control Wheel

Topic: Sorting Out Messages

People with multi-abuse trauma issues may be receiving services from several different providers. For example, they may be seeing a victim's advocate for domestic violence, sexual assault or stalking, a treatment counselor for substance abuse or dependence, a therapist or psychiatrist for mental health issues, and a social worker for assistance finding housing if they are homeless. In the process, people experiencing multiple issues may begin to acquire multiple labels. People receiving help from a variety of sources may also hear messages that seem to conflict or contradict each other.

In the skit, "*Mary Has All Kinds of Troubles*," ask for several volunteers from the audience to play the part of the "helping professionals," the part of "Mary" (the person seeking services), and the part of a volunteer who will tape labels on "Mary" while the "helping professionals" are speaking. Following this role-play exercise use the skit and the other handouts to discuss how to help people who use our services to better navigate conflicting systems and advice, as well as the pros and cons of using labels.

Note: You will need to do some advance planning for this skit. For each role, you may want to use a highlighting pen to highlight actors' parts in their copy of the script to make it easier to follow. (For example, you will highlight the "substance abuse counselor's" part in the copy of the script that you give to the person playing the role of the substance abuse counselor, the "mental health professional's" part in the script given to the person playing the role of the mental health professional, etc.) Review the script and write assorted labels such as *victim*, *drug addict*, *borderline*, etc., on several sheets of 8 ½ X 11 paper. These can be taped on "Mary" by the volunteer while the "helping professionals" are verbally labeling this individual. Once you make up your labels you may want to laminate them for future use.

Handouts

Skit: Mary Has All Kinds of Troubles
Sorting Out Messages
To Label or Not to Label?

Topic: Unhealthy Social Messages

Naomi Michalsen, Executive Director of Women in Safe Homes in Ketchikan, AK, shares an exercise she uses to help people understand social attitudes and their impact on the personal level. Make a list of a couple dozen or so behaviors and attitudes often seen in our society, or in movies or on television. Some examples may include:

- A coach telling boys, "You're playing like a bunch of girls."
- Assuming girls are not as smart as boys at math.
- Insisting a woman's place is in the home.
- Mud flaps on a truck with a woman's silhouette.
- A billboard that says, "Come see hot young chicks" and has pictures of baby chickens.
- Ads or movies or television shows with violent themes or imagery.

Someone's partner calls frequently or drives by their house to check if they're home.
Shoving someone during an argument.
Hitting someone during an argument.
Being forced to have sex while on a date.
Rape/sexual assault by a stranger.

For each attitude or behavior on the list, ask, "Is this harmful?" When the group has discussed whether a particular item is harmful or relatively harmless, point out how things that may seem harmless or even funny can chip away at the value that society gives women, or may increase societal tolerance for violence or abuse.

Supplies

Newsprint paper and markers

Topic: Why Don't They Trust Us?

Few things are more frustrating than trying to work with someone who obviously doesn't trust us. However, past experiences with interpersonal violence and other trauma may have made trust difficult for the people who seek our services. Discuss some of these experiences, and how they might impact a person's ability to trust others – including advocates, counselors and other service providers, as well as institutions and authority figures. Discuss ways for helping professionals to earn the trust of the people they serve.

Handouts

Trust Isn't Always Easy
Gaining Trust

Topic: Safety Planning

Advocates for victims of interpersonal violence encourage the people they serve to develop a safety plan. However, "safety" can mean different things for different people. For individuals with multiple issues, safety, sobriety, wellness and accessibility may all need to be priorities. Discuss how a safety plan can be modified to include issues such as recovery from substance use disorders, mental health concerns, accessibility for people with disabilities, unsafe environments in a dangerous neighborhood or prison setting, etc.

Mental health providers, substance abuse counselors, disabilities advocates and other providers may also help the people they serve develop treatment plans, recovery plans, or other types of service plans. Discuss ways to incorporate safety issues into the plans created by these other providers.

Handouts

Personalized Safety Plan
What Does Safety Mean?
Mini-Safety/Sobriety/Wellness Plan (With Instructions for Use)

Topic: Power and Control Dynamics

Judith Herman, M.D., author of the book *Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror*, emphasizes most interpersonal trauma is embedded in a social structure that permits the abuse and exploitation of people in subordinate groups. Use Power and Control Wheels to illustrate all the various ways power is used and abused in our society, and in our personal relationships, to dominate and control others.

In addition to educating others about interpersonal violence, the wheels can be useful for exploring issues such as mental health concerns, substance use disorders, disability issues and various kinds of social oppression, with an eye toward ways power dynamics can impact an individual's ability to address these issues. The Wheels can also be used to explore the use and abuse of power in various settings ranging from intimate relationships to schools, social service agencies, other institutional settings and communities.

Use the "equality" wheels and community collaboration and accountability wheels as a basis for discussion of ideal behaviors and responses in personal relationships, institutions and the community.

Handouts

Power and Control Wheel

Abuse of Children

Children Coping With Family Violence Wheel

Power and Control Model For Women's Substance Abuse

People with Disabilities and Their Caregivers: Power and Control

Gay, Lesbian, Bisexual and Trans: Power and Control

Immigrant Power and Control Wheel

Power and Control Wheel for Women Involved in Street Prostitution

Violence Against Native Women: Battering

Bullying Power and Control Wheel

Power and Control in Dating Relationships

Abuses Endured By A Woman During Her Life Cycle

Equality Wheel

Nurturing Children

Mental Health System Power and Control: Empowerment

People with Disabilities and Their Caregivers: Equality

Natural Life-Supporting Power Wheel

Ideal Institutional Response

The Benefits of Collaboration

Discuss the advantages when providers from different agencies/disciplines cooperate for the benefit of the people we mutually serve. Depending on the target audience, the Wheels can also be used to demonstrate characteristics of successful collaborations.

Handouts

Advocacy Wheel

Successful Collaboration Wheel

Coordinated Community Action Model (Wheel)

Community Accountability Wheel

Community Faith Leaders (Wheel)

Judicial Responses that Empower Battered Women (Wheel)

Domestic Violence: A Cross-Cutting Issue for Social Workers (Wheel)

Topic: Parenting and Children's Issues

Children may not talk about problems they witness in the home, so it can be tempting to think they don't notice what's going on, or that it doesn't affect them that much. But research tells a different story. Discuss the impact of both substance abuse and violence on their children, as well as how to create a more positive environment for children.

Handouts

Children Exposed to Domestic Violence and Substance Abuse

Abuse of Children Wheel

Children Coping With Family Violence Wheel

Nurturing Children Wheel

Safety Planning Interventions for Children

Topic: Working for Change

Many people who have survived trauma, especially trauma caused by interpersonal violence or social injustice and oppression, find working for social change aids their own healing process. People may call their efforts working for change, service to others, or carrying the message. Discuss contributions from a variety of social movements – the women's movement, the recovery movement, the mental health movement, the disability rights movement and civil rights movement – that have made it easier for people to get help with problems that were once denied or stigmatized. Discuss how to help survivors work for change while maintaining their own safety.

Handouts

Can One Person Make a Difference?

Writing a Letter That Gets Attention

SAMPLE TRAINING LOGISTICS GUIDE

1. Focus where you will provide training based on community need, interest expressed by agency or local community service provider. Be intentional.
2. Create a folder for each site to be contacted. Document each contact, whether it is by e-mail, phone, fax, in writing or face-to-face.
3. On each folder indicate:
 - Training site name, address, phone and fax numbers, e-mail address.
 - Training site manager's name and phone number as well as your contact information if different from the manager's.
4. Once a training is scheduled, include the following in the file:
 - Directions to the training site and room number or location of the training.
 - Contact name and phone number of the person who will be present the day of the training should questions or problems arise. This person will also be responsible for helping the trainer collect sign-in sheets and evaluations.
 - The number of people to be trained and, when applicable, background on the participants. For example, are they advocates? Substance abuse, health care or mental health providers? An interdisciplinary team? Educators? Other?
 - Indicate whether the participants to be trained have indicated a particular area of interest. For example: Domestic Violence/Sexual Assault 101? Trauma Issues? Substance Abuse?
 - Note technical training needs and whether the training site has an overhead or slide projector, TV-VCR, laptop, PowerPoint projector, audio equipment (including microphones) white board, blackboard or paper and easel, as well as writing implements such as markers or chalk.
 - If the above is unavailable, advise the trainer to bring paper, markers and tape, a portable overhead/slide projector, or other equipment as needed.
 - If doing training over an hour long, be sure to consider at least some video or audio clips and request a VCR. Document your plans in the file. Plan to arrive early to check on your technical equipment and make sure it is working and *ready for use*. Always have a back-up plan.
 - Indicate whether or not participants will be eating a meal during training so the trainer can factor in how much time to allocate for the meal before passing out pre/post tests, etc.
 - Indicate the name of the trainer responsible for training.
 - All training should include both an advocate and someone from the community, most often someone drawn from the place where you are training.

- Be sure to schedule time to discuss input from your community partner prior to training. When the training is scheduled, indicate the name of the community partner who will co-train with the advocate.

5. Note in file whether this is first, follow-up or repeat training. Also indicate any special information which would be of use to the trainer. For example, health care staff want advanced training on domestic violence/sexual assault, advocates are interested in substance abuse and mental health issues and domestic violence/sexual assault, community wants training on working with special populations.

6. When the training is scheduled, send a confirmation letter or e-mail to your contact at the training site with all pertinent details summarized. A copy of this letter/e-mail should be sent to your co-trainer as well.

7. Following the initial training, training site contacts should be contacted regarding follow-up meetings to discuss how the training went and other training or community service goals or issues. A copy of training materials or brochures should be mailed to the training site manager and interested parties who may not have been able to attend your training. Additionally, encourage participants to explore volunteer participation in our programs. Make every effort to foster a relationship between the domestic violence/sexual assault program and the community agency you are providing training for.

8. Place training sites on a booster schedule and mail appropriate flyers and program information to them several times a year (*every three months is often a good schedule*). Booster material may include screening cards, pens, buttons or posters.

9. Create a tickler file to remind you to contact programs you have trained in the past so you can maintain your connection and prevent relationships from slipping through the cracks. Determine whether your staff needs more advanced or specialized training, and schedule as needed. Make phone calls to see how your training contact is doing. Encourage linkages between domestic violence/sexual assault and other community programs.

10. Whenever a training site receives training, check to see if they want to put information about the training in their newsletter or report it in the local press.

11. Trainers need to be prepared prior to arriving at a training site. They are responsible for having a proper number of handouts with them as well as brochures and information unless the training site agrees to make the handouts. Also before leaving to provide training, trainers should ask themselves: Do you have directions to where you are going, your video, overheads, zip drive or disc and projector? Do you have enough pencils, markers, a sign-in sheet, a driver if necessary, tape, large sheets of paper, posters, etc? Additionally, has the trainer found interesting articles or facts to supplement the basic curriculum? Another option is to assemble a list of additional articles for the training participants to explore on their own.

12. Routinely check on supplies on the first Friday of each month: folders, brochures, safety plans, books, pamphlets, and other materials such as pens and markers. Update your training calendar weekly.

TRAINING LOGISTICS

Date 	Training type? 	Contact Person 	When/Where? 	Trainer(s) 	Community Liaison 	Equipment needed? 	Who's Driving? 	How Many Attending? 	Hand-outs ready? ✓ if yes

COMMUNITY EDUCATION AND ACTIVISM

People who are survivors of multiple traumas – and who fall through the cracks of systems designed to help them – often do not get much empathy from the larger community and society. This reality becomes readily apparent when we listen to talk shows, read the responses to news articles about funding cuts for human services, or engage people around us in conversation about the work we do. We've all heard the comments:

“Why don't those people stop whining and get a job?”

“I don't want to sound judgmental, but don't they create their own problems?”

“There's no problem that a dose of personal responsibility won't solve.”

“I just HATE victims!”

While it might be tempting to ignore such comments after dismissing them as naïve and narrow-minded, we do so at the risk of those we serve. When politicians who want to win elections listen to this rhetoric, the result is all too often draconian policy decisions and state or federal budgets balanced on the backs of marginalized people. And this impacts our own ability to help the people we serve effectively.

Interpersonal violence, in particular, is a problem that thrives in the face of public attitudes that blame and hate victims. Holding abusers accountable for their behavior – and getting others to do so as well – is critical to our work as advocates and community partners who help people impacted by violence or abuse.

Judith Herman, M.D., author of *Trauma and Recovery*, points out complex trauma stemming from interpersonal violence or abuse is always embedded in a social structure that permits the abuse and exploitation of a subordinate group (Herman, 2009). Therefore, providing community education designed to address the underpinnings of violence – such as racism, classism, sexism, homophobia and ableism – is also a critical element of our work to end interpersonal violence and end oppression on all fronts.

Given these realities, some advocates and other social service providers have stopped asking, “Should we get involved in social change efforts?” Instead, they've begun asking, “How can we get involved most effectively?”

Cindy Obtinario, chemical dependency/domestic violence specialist at New Beginnings in Seattle, WA, has been very active in educating the public as well as providers in other disciplines such as mental health and substance abuse treatment. She says:

“I talk about domestic violence as an issue of oppression at many levels. It's not just

a problem between two intimate people. These two people are affected by their families, their communities, their culture, their nation. I talk about domestic violence as a societal issue of oppression with multiple layers.”

Naomi Michalsen, executive director of Women In Safe Homes in Ketchikan, AK, explains why she thinks educating the public is so important:

“Oppression is something we don’t want to talk about still. We think we’ve gotten so much further, but we really have to hit the racial barriers, the cultural barriers. All those things are huge. ... When we’re talking about white privilege, or male privilege, many young people don’t know what that means. If you ask all the eighth graders in Ketchikan, men and women *are* equal already, so we don’t need to work on that. They don’t realize how the women’s movement came about, and why it came about, and how long it took, and how far we’ve come. It’s like we almost have to go back again and learn our history before we can make it apply to us and understand it. That’s a tough job. ”

Karen Foley, a behavioral health specialist and intensive case manager in the Pacific Treatment Alternatives Safe Babies/Safe Moms Program in Seattle, WA, says:

“I do everything in my power to try to change social attitudes and agency practices. I teach at a community college. I teach up-and-coming chemical dependency counselors how to better work with people with a history of mental illness and/or domestic violence/sexual assault. I listen to clients. I also try to learn not only from clients, but to continue my education in the areas that I’m not well versed in. I encourage changes in my agency and in my community, and I challenge attitudes and beliefs of racism and sexism. And then I started my social change nonprofit called Triple Play.”

A survivor of multi-abuse trauma shares:

“I really believe that each of us has a gift and each of us has something to share, and each of us can make a difference. So even if I talk to 500 people and one person might be touched, I keep doing what I’m doing.”

Triple Play Connections is a Seattle-based nonprofit organization comprised of mental health, domestic violence, sexual assault and chemical dependency providers working together to cross-train and network in local neighborhoods throughout Washington State, using best practices with a focus on cultural competency. The organization has neighborhood network groups and an annual training conference. Says Ms. Foley: “It’s totally self-sufficient. You don’t need funding. You just need the desire.” She adds she would love to help people start a similar organization in their communities. (See our Appendix: Additional Resources for information on how to contact her.)

This section will provide a broad definition of social activism in its various forms, take a look at the ways that working for change benefits advocates, community partners and the people we serve, and offer tips for getting media coverage and lobbying elected officials. The tips in the previous section for giving presentations will also prove helpful when carrying your message to schools, civic organizations and places of worship.

What is social activism, exactly?

The ability to deliver effective services depends on a strong voice in government and improved community understanding, as well as advocacy or counseling skills.

When we think of social activism, a definite image often comes to mind. We envision people taking to the streets, marching and carrying signs proclaiming their cause to the world. Or we envision a crowd gathered in a public arena, listening as a series of speakers fire up the crowd to take action in support of their cause.

While marches and rallies are time-honored forms of social activism, there are numerous ways for people to get involved in working for social change. Other actions qualifying as social activism range from community education to involvement in coalitions that work for change and writing letters to legislators or television show sponsors. Activism can be very public, or it can be a behind-the-scenes endeavor (an important factor for survivors with safety concerns).

Here are just a few examples:

- *Lobbying.* This includes tracking public policy and legislation that has the potential to impact the people we serve, and persuading elected officials to make the appropriate decisions. Lobbying activities can range from calling or writing legislators to testifying before legislative committees and organizing formal Lobby Days.
- *Public education.* A variety of public education efforts can be used to change societal beliefs about interpersonal violence and the people victimized by it. Schools, places of worship, civic organizations and public television stations are just a few of the venues that advocates and community partners can target for educational presentations.
- *Media campaigns.* This can include paid advertising in news outlets or on billboards, or free media coverage in the form of news articles, radio or television programming or public service announcements. This can also include monitoring advertising and other media for accurate or inaccurate messages about the people we serve as well as messages that seem to glorify violence or promote negative stereotypes, and contacting editors or sponsors to let them know our feelings about these messages.
- *Grass-roots organizing.* This means encouraging as many people as possible to join us in all of the above efforts. There is strength in numbers. One person or organization can too often be easily ignored. When several people or organizations join together, people begin to take notice.

The benefits of social activism

Working for social change is an excellent way for survivors to channel the normal anger that results from having been abused or oppressed. Public engagement also benefits advocates and other providers who sometimes feel frustrated in their efforts to help make the system work better for people who need help.

For some people who have survived trauma, activism offers one way to heal from the violence or abuse. Says Judith Herman (1997):

“These survivors recognize a political or religious dimension in their misfortune and discover that they can transform the meaning of their personal tragedy by making it the basis for social action. While there is no way to compensate for an atrocity, there is a way to transcend it, by making it a gift to others. The trauma is redeemed only when it becomes the source of a survivor mission. Social action offers the survivor a source of power that draws upon her own initiative, energy, and resourcefulness but that magnifies these qualities far beyond her own capacities.”

Social action on the part of survivors can take many forms (Herman, 1997):

- *Helping others who have been similarly victimized.* Survivors may become volunteer advocates at rape crisis centers or domestic violence shelters, or advocates for other victims in court. Or they may share their experience with other survivors in a support group setting.
- *Political involvement.* This may involve educational, legal, or political efforts to prevent others from being victimized in the future. Some survivors have gotten involved at the legislative level, by participating in letter-writing campaigns or lobbying efforts, or even testifying before legislative committees about their experiences.
- *Attempts to bring offenders to justice.* Many survivors believe holding the perpetrator accountable for crimes is not only important for their own personal well-being but also for the health of the larger society and for other victims. For many survivors, the act of reporting the crime to police or going to court is helpful in and of itself, regardless of the outcome the case.
- *Educating others.* Many survivors have shared their experiences and success stories as a way of offering hope to other survivors, or have told their stories at conferences and other training venues to help educate service providers about the needs of survivors.

A survivor shares: “I just told my story a couple of weeks ago to some providers, with the intent of sharing the different pieces about medical health, mental health, chemical dependency and domestic violence so they can know, when they get a call, to keep their eyes open to make sure they are referring appropriately, depending on what somebody presents with. I’m using my story to help do that.”

Another survivor shares: “I try to use my experiences in the schools and other

SAFE WAYS FOR SURVIVORS TO WORK FOR CHANGE

Advocates and other providers sometimes get nervous when the people we serve talk about getting involved in social activism efforts. What about safety? Are they ready for this, or should they be taking care of their own issues first? However, there are usually ways even for people in the early stages of recovery and healing to participate safely:

- ***Breaking the silence.*** Going to a support group meeting and sharing one's personal story can be a radical act! Our society encourages people to stay quiet about certain issues. When one person says "I have the disease of alcoholism" or "I've been abused," others find it easier to break *their* silence.

- ***Contacting people who make decisions.*** This may include complaining to TV stations about violent programs, calling radio stations that play music glorifying drug use or abuse in relationships, or writing to advertisers who promote stereotypes or sponsor objectionable programs.

- ***Talking to their children.*** Parents can discuss the violence portrayed in TV shows, movies and video games, help their children understand what happens when people do these things in real life, and educate their children about alcohol and drug abuse, dating violence and other dangers.

- ***Getting involved politically.*** Make sure people you serve know how to get registered to vote. Encourage them to write or call elected officials about issues that affect them.

- ***Getting involved in the community.*** Where it is safe to do so, encourage survivors to join organizations that work for change. Faces and Voices of Recovery and National Alliance on Mental Illness are examples of organizations that work to get appropriate support from governments and the public for people in recovery.

- ***Being a role model.*** Hosting a potluck or social gathering where no alcohol is served, refusing to buy violent toys or video games for children, and explaining to others why one refuses to use corporal punishment with one's children are all actions that make a statement, both to children and other adults. A survivor shares:

"Today, I want to carry that torch and say, 'We can overcome. We can survive. We can succeed. We can be brave. We can have the courage.' I am an example to many, many young women. I'm their role model. Look at myself. I am someone who experienced severe domestic violence, and I am successful today. I thought I would never take a peek at the world ever again – that I would be six feet below on account of someone else's hands, that my blood would be on the palms of their hands. And before that ever happened, I am very successful today. And it takes a lot of strength."

settings now to help, whether they hear it or not. ... I really believe each of us has a gift and each of us has something to share, and each of us can make a difference. So even if I talk to 500 people and one person might be touched, I keep doing what I'm doing."

Common to all these efforts, says Herman (1997) is a dedication to raising public awareness. Using the police and the courts to pursue justice, or participating in consciousness-raising activities, are ways to defy the perpetrator's attempt to silence and isolate victims and open the possibility of finding new allies.

Social activism can also hold benefits for advocates and their community partners:

- A study of sexual assault program coordinators found that an ability to influence public policy was a particularly rewarding part of their job. Central to their positive experiences was the focus on working with women and advocating and lobbying on their behalf (Carmody, 1997).
- Advocates and other providers may also feel anger about attitudes, actions or statements from criminal justice personnel, including police officers, judges, detectives, defense attorneys and prosecutors; toward the perpetrators of the abuse; and toward societal attitudes about women and other marginalized groups (Wasco & Campbell, 2002). Social activism can be a productive way to channel this anger. As such, it can help advocates and other providers avoid the burnout and vicarious trauma that can result from anger that's not channeled in a healthy way.
- Many providers report a sense of higher purpose in life and a sense of camaraderie that allows them to maintain optimism in the face of horror (Herman, 1997).

Packaging your message

A good way to start your community education and activism efforts is to create an attractive information packet. These packets can be used in a variety of venues to educate the public about your agency and its services, create an accurate picture of the realities faced by people you serve, and combat myths and stereotypes.

Some things to include in the packets are prepared statements, news releases, fact sheets, graphics or photos to go with news releases and fact sheets, pamphlets promoting your program or agency, and background on the agency itself such as detailed information about your services, number of people served, names and phone numbers for contact people, and other significant information.

Fact sheets are one- or two-page summaries of a given topic. They may be handed out at press conferences, sent to media outlets with press releases, distributed to elected officials during lobbying efforts, or used as follow-ups to telephone calls. Distilling information into a fact sheet helps reporters, legislators and other members of the public understand your message.

Getting press coverage

While paid advertising on billboards and buses (especially for hotline numbers) can be an effective way to promote your services, it can be expensive. Fortunately, you can take advantage of free media – from news articles and op-ed pieces to public service announcements – to not only promote your services, but also debunk myths and educate the public.

Because the news media has power to help or hinder you in promoting your message, it's to your benefit to create a positive relationship with the press. The good news is, most journalists do strive to be fair and responsible. But they have extremely tight deadlines and space restrictions, and some may be relatively inexperienced. The easier you make their job, the more you help them get a clear and accurate message to the public. Here are some tips on the care and feeding of journalists:

- Suggest ideas yourself, especially for feature stories. On any given day, many feature stories will have originated from tips provided to editors by the public. Feature material could include new or highly successful programs, agency anniversaries, significant grant awards, staff promotions or new staff profiles (especially a new director, or a new staff position made possible by grant funding).
- Get to know the players. If certain reporters regularly cover social service issues, learn who they are and provide them with a regular supply of information. If you don't know who in a specific organization would cover your kind of story, contact the city editor (print), assignment editor or news director (broadcast).
- Designate a press area. At public events such as rallies, forums or educational programs, have reserved seating or a press area large enough to accommodate camera crews. Provide information packets to reporters in advance of the event so they can have a better understanding of topics to be discussed. Also spend a few minutes after the event answering press questions.
- Return phone calls. Always return reporters' calls as promptly as possible. Deadlines do not wait for you or the reporter. Two hours late is too late.
- Think in terms of sound bites. When speaking with a reporter, keep interview answers simple and short, especially with radio and television reporters. Ten to 15 seconds is best for broadcast "sound bites." Long, complicated answers put the burden on the reporter to determine which information is most important. State your conclusion, then your substantiating data. Hit your bottom line first.

Press releases

Press releases are an effective way to relay information of interest to several media outlets at once. They are appropriate for announcements of public events, fund-raisers or

staffing decisions such as hiring a new director. A press release can also be an effective way to present your response to a controversial issue, such as a new television show that promotes negative messages. Following are a few tips for effective press releases:

- Give the press release a professional look. Use agency letterhead stationery or a letterhead specifically designed for news releases. Type all copy double-spaced or even triple-spaced to leave room for a reporter's editing, and use only one side of the paper. If sending the press release online, use only standard typefaces such as Times New Roman or Helvetica, or use the PDF format, to ensure that messages don't become garbled in transmission.
- Give complete information. For each person mentioned in the story, use first and last names and identify the person by title, position, or reason for being included in the story. Date your story and indicate the date it may be printed. (You'll generally use the words FOR IMMEDIATE RELEASE.)
- Include graphic elements. Mention opportunities for photos, or include good quality photos with the release. Identification of people in photos should be on a separate piece of paper pasted to the back of the photo, not written directly on the photo. Charts and graphs can also add visual impact to a story, especially when confidentiality concerns restrict the use of photos. If photos are used, make sure everyone in the photo has signed a photo release.
- Keep it short. Write concise sentences and keep paragraphs no longer than about four sentences. The entire press release should be two pages or less.
- Use what journalists call the "inverted pyramid" style. Who, what, when, where, why and how are the essentials – and as many of them as possible should be in your lead paragraph or two. If you save important information for the end of the story, you may never see it in print or on the air.
- Pay attention to deadlines. Some sections of daily papers are printed in advance (the community calendar, for example) and weeklies may work one or two weeks in advance. For television and radio, find out when news directors are planning their stories.
- Be available for more information. Be available to assist the reporter who wants to follow up on a press release. For example, a reporter may want to interview additional people, or want photos or graphs to go with the story.
- Always include contact information. Include contact persons and phone numbers on everything, even short press releases, in case a reporter has questions or wants to follow up with a feature story. Better yet, provide two contact people in case one of them is not available at the time a reporter calls, and include a home phone number or cell phone number for at least one person.

Press conferences

A press conference allows you to reach all media simultaneously, and to have all your own experts in one room for statements and interviews. Press conferences need not be intimidating, and are an excellent way to obtain the kind of coverage you need to get your message to the public. When giving a press conference:

- **Believe in the “newsworthiness” of your story.** A news conference is appropriate for the announcement of important new programs or services, as well as for major grant awards. (This gives you an opportunity to publicly recognize your funders.) Join together with other social service providers for a press conference about the impact on your programs of government legislative or budget decisions. Other events such as “Violence Prevention Month” can also provide occasions for news coverage.
- **Observe deadlines.** Know and respect the reporters’ deadlines, so you know when – and when not – to schedule a press conference. Schedule the event several hours before that day’s deadline for both print and broadcast media.
- **Think outside the box.** Don’t limit your idea of “media” to the large newspapers and TV stations. Small, regional weekly or monthly publications, student newspapers, and newsletters put out by your local chamber of commerce or other community organizations also qualify as media. Their staff should be sent press releases and invited to news conferences.
- **Be prepared.** Have experts on hand who can be called on by reporters with questions. All those who will speak or who may be called on should be briefed beforehand on anticipated questions and the parameters of their responses.
- **Provide refreshments.** Coffee, soft drinks and doughnuts or cookies add a nice touch.

Other external communications

Fortunately, you don’t have to depend totally on the news media. Several creative ways exist to take your message directly to the public. You have two options: take your agency into the community, and bring the community into your agency. Here are some ideas:

- **Newsletter.** Create an agency newsletter that goes out to potential donors, elected officials, business and community leaders, churches, doctors’ offices and public events.
- **Tours.** Conduct agency tours for legislators, business and community leaders, members of the clergy and other interested parties.
- **Speaker’s bureau.** Establish a speaker’s bureau to give presentations for religious or civic groups. Include both staff and board members or volunteers. Develop a presentation kit with handouts and PowerPoint slides about your agency for anyone who will be doing

the community presentations. Suggest programs to community groups that could be furnished by your staff or volunteers.

- *Luncheons*. Have informal sessions (luncheons, coffees) where staff can meet with small groups of business people, legislators and other community leaders.

Organizing the community

For agency staffs working to manage critical issues, few efforts are more important than that expended to build grass-roots coalitions within the community to support your goals and your message. In addition to helping you provide better services to survivors of trauma, coalitions can form a united front to address or influence legislative activities.

Coalition groups can be organized in any number of ways; in fact it's likely no two groups will be identical. They may be local or they may link up with similar groups in other communities to form a regional or statewide network.

Some groups, such as statewide domestic violence and sexual assault coalitions, are highly sophisticated organizations with their own offices, board members and staff. Others have no formal structure, but consist of loose networks of individuals or organizations that can be relied on to take part in a telephone or letter-writing campaign when the need arises. On a local level, this may include staff from domestic violence or sexual assault agencies working together with community partners such as law enforcement agencies, public health organizations, groups that serve children, etc.

Developing a coalition will increase your power base with elected officials in several ways:

- Your coalition will give the appearance of a large number of constituents who have an interest in an issue.
- The coalition can form a united front to influence legislative activities.
- Developing working relationships with other agencies or groups as well as elected officials can be valuable in a crisis.
- Members of a coalition can organize candidate forums or debates, publish voting records and provide information for the public on important issues.

When working with coalitions, keep in mind that *members won't always agree on every issue*. The best group leaders can do is to present accurate information and let people make up their own minds about whether they support a particular priority, position or activity and whether they think it's worth working for.

USING SOCIAL MEDIA TO PROMOTE YOUR MESSAGE

Social media can be a great way to promote your organization and spread your message to the people you wish to serve, partner organizations and the community. However, there are some important questions for you and your organization to consider which can help you determine if social media is worth your time and investment.

What is your goal?

Know your goal and be clear about your intent. For example:

- Is your intent to provide advocacy or to promote events that raise awareness?
- Do you want people to take action – sign a petition, attend an event?
- Are you looking at raising awareness about your issue generally or a specific concern?
- Do you want to enhance outreach efforts to the general public or a specific group?

Who is your audience?

Identify your target audience. Who you are trying to reach will determine what methods and tools you use, and how to craft your message to engage your audience.

What medium will accomplish your goal?

There are many mediums to choose from, depending on your goal and your audience:

- ***E-mail***. Sending messages to a group or distribution list is a great way to quickly send information and updates.
- ***Blogs***. Creating spaces for public discussion can engage your audience in conversations about topics that matter to you and your organization.
- ***Social media (Facebook, MySpace, Twitter)***. Millions of people use social media to connect with family and friends, but they're also connecting with groups and organizations that make a difference in their communities.
- ***Media Sharing (YouTube, Vimeo)***. Making training videos, commercials, and public service announcements available online is a great way to spread your message online.

What message will you convey?

You want your message to be clear, succinct, and memorable. Too much information will overwhelm an audience and information that is too vague will be ignored, so pick strong points that are interesting, timely, and relevant. In this digital age, people are overwhelmed with information so make your message stand out!

What resources will it take?

Many online tools are free or inexpensive to use, but what we often don't factor are time

and energy. Your agency's capacity to create and maintain online organizing efforts needs to be considered carefully. Online relationships don't just happen. They need to be cultivated. Just putting up a page does not engage an audience. Outreach and continued presence as well as engaging messaging are essential.

Evaluate the 'What If?'

Finding ways to evaluate your efforts in online activism can be difficult. Define for your agency what success is, and continue an ongoing evaluation of your success goals. Social media tools should be integrated into your overall marketing and communications plan, not looked at as separate from each other. Search the web and you will find many online resources that will guide you in an evaluation process. Check out techsoup.org. They have a great deal of expertise and information for non-profit organizations on social networking and other issues.

What to post?

Keep in mind that nothing online is completely private, and once it is posted you can't take it back! Even if you delete the information it is possible to search archives that could pull up the picture you didn't get permission to post, or the comment you accidentally posted to your page and immediately removed.

Depending on the social media you use, you can often set privacy and posting settings to filter responses others make before you allow the post to be viewed on your site. It is important to actively monitor your site if you do allow posts so inappropriate posts are taken down or dealt with immediately. So, think about what you are sharing online: Who will be able to see the information? Is it reaching your target audience? Does it represent your organization in a way that enhances the organization or your work?

Who is allowed to post?

Because social media is about connection and dialogue, an agency should think through who within the organization is allowed to post and/or respond to discussions, questions, and comments. It's a good idea to have guidelines on how the moderator will respond to posts, especially if the post is inappropriate or contains sensitive information. Also, most sites have content policies to follow, so make sure you read these policies to ensure posts to your page are in compliance.

How will you respond to posts?

If you open the gate and allow friends to post, it is a good idea to have a policy informing your "friends" what the rules or expectations are. This will help cut down on posts that may be off topic, malicious or flame-fanning, contain sensitive or private information, or just be inappropriate. Once you have a policy in place, it is a good idea to post your policy on how you intend to respond and monitor your site.

Assess the Risks

How can posts risk staff and client safety? For example: If you advertise on your site that you offer certain services and also list the location, days and times you will be offering these services, is it likely your employees or the people you serve could be negatively targeted? Abusers could be tipped off that their victims are accessing the listed services and show up to harass or use other tactics to stalk (i.e., slash tires, follow her, continue to call constantly during that time period to impede her participation).

It is important to do our best to inform users on privacy and safety when using these sites, so they can make more informed choices about how they choose to communicate and interact. “Friends” can be survivors, advocates, or friends of friends, but they all need to be aware of the potential dangers so they do not put themselves at risk of being monitored. Many people who use social networking are unaware of how being a friend on a page can possibly lead to stalking and harassment. Here is an example of a simple safety alert:

SAFETY ALERT: If you are in danger, please use a safer computer, or call 911, your local hotline, or the U.S. National Domestic Violence Hotline at 1-800-799-7233 and TTY 1-800-787-3224. See more technology safety tips here:

<http://www.nnedv.org/internetsafety.html>

Photos

Pictures are a great way to engage friends and share the spirit of the work you are doing. Keep in mind, just like with our newsletters, it is important to get permission from people in the photo before posting it online. Not everyone wants to be “famous.” Someone in the picture could be a survivor in hiding and the picture and its description could give away confidential information. One strategy would be to let everyone know you are taking a photo that might be published in a newsletter or on the Internet. This allows people to opt out of the photo or at least let you know they do not want the photo circulated.

Survivors & Social Media

Often survivors find our organizational sites and ask to be “friends.” Survivors may wish to share information about themselves or others on your social networking site. Depending on the details and information shared, sharing personal stories on a social network page may open the survivor and owner of the site to legal action. Survivors should be informed of the safety and legal risks associated with sharing personal information online. Follow the policy guidelines you have in place on what others can post on your site.

We strongly suggest programs do NOT solicit information about abuse or conduct counseling or advocacy using social networks. However, because social networks can be an access point for survivors to reach out, programs should include hotline numbers, contact information and Web site links in their profiles.

Adapted by Lindsee Acton from 2 “Post” Or Not 2 “Post,” a PowerPoint presentation created by Teresa Atkinson for the Technology Safety Project of the Washington State Coalition Against Domestic Violence, 2008.

Lobbying elected officials

Lobbying can take many forms – letter-writing campaigns, petition drives, personal visits with elected officials, telephone calls, providing background information about your issues, testimony before legislative or local government committees, and even an official Lobby Day. Here are some things to keep in mind when lobbying elected officials:

- Don't be intimidated. Some people think authority figures such as legislators or the governor are out of the reach of ordinary people. However, they are generally quite approachable. Most lawmakers are glad to hear from their constituents, and those that aren't should be suspected of not doing their jobs.
- Coach group members. Be sure all members of your lobbying group know the basics of how to approach elected officials and have solid background on the issues before they start writing letters or charging the Capitol. Offensively aggressive or ill-informed members can destroy a group's credibility quickly.
- Pace activities. Effort may be needed at every step of the legislative process, right up until the moment the governor or president acts on a bill.
- Keep in touch with elected officials on an ongoing, year-around basis. Be sure they get to know your group and what it represents. When appropriate, send notes of praise and encouragement.
- Be realistic. Realize from the onset that lobbying can be frustrating – being right is no guarantee of winning. A clear understanding of the legislative process will help members of your group have realistic expectations.
- Anticipate that maintaining interest may be a problem. Some hot topics generate their own interest, but some of the most important issues are dull. Funding for human services is a notable example, but nothing is more basic.
- Seek legal advice. As long as all members of your group are volunteers for lobbying purposes and stick to issues affecting the people they serve rather than endorsing particular candidates, they may not need to be registered as lobbyists. Organizations receiving various types of government funding have less latitude than individuals. If in doubt as to which kinds of lobbying can be done without getting your agency into trouble with funders or jeopardizing your tax-exempt status, seek legal advice.
- Express appreciation. Conclude any lobbying effort by sending appropriate thank-you notes to legislators, representatives of organizations and other volunteers who assisted in any way with the lobbying effort.

The fine art of letter writing

Writing letters to the editor, to legislators, or to TV and radio advertisers is a great way to convey your position on issues that impact the people you serve. And recipients do pay attention. Legislators want your vote. Advertisers want your business. When they get even a few letters from different people, it begins to have an effect.

When writing to an elected official:

- In the first paragraph of your letter, describe the bill you want your elected official to consider. Whenever possible, refer to a specific bill by name and number, and not just to a vague issue. Make clear what your position is, and what exactly you want your legislator to do (vote for or against the bill).
- In the next paragraph or two, explain who you are. Tell your legislator how the bill would affect you, your agency, the people you serve, or your community. Express your thoughts in your own words, and make specific references to key points in the legislation. A personal story is very effective, and is your best supporting evidence.
- In the last paragraph, reiterate your support or nonsupport of the bill and ask the elected official to state her or his position in a reply. Thank the legislator for taking the time to read your letter, and express the hope that he or she will give this important issue due consideration.
- Finally, sign your full name and address so your legislator can respond.

Here are some general tips on how to make your letter effective and get your point across, whether you're writing to an elected official, a TV program sponsor or a letter to the editor of your local newspaper:

- Keep your letter short and to the point. Write about one issue in each letter. Remember, some recipients may read hundreds of letters each week.
- Letters should be in your own words. Petitions and letter-writing campaigns with identically worded contents are not as influential.
- Type or write legibly on your own personal stationery or letterhead. The envelope should be plain white and hand-written (don't use pre-printed labels).
- You may write to any elected official, but you have more influence in your own district where you vote. If you are a constituent, say so. If you supported or voted for the legislator, say that also. (If you didn't, say nothing.)
- Be polite. Avoid language that demonizes or insults the reader.
- Remember to say thank-you.

ORGANIZING SUPPORT GROUPS

Support groups can serve as a valuable adjunct to individual advocacy or counseling. These groups provide opportunities for participants to discuss their daily struggle with the multiple issues affecting their safety, sobriety, wellness and empowerment.

Much of the power in support groups comes from the personal stories. People share their experience, strength and hope with each other. When one person breaks the silence about personal experiences that are uncomfortable or “taboo” to talk about, others feel safer breaking *their* silence.

Members of the group also hear success stories. They hear what others are doing to cope with problems similar to their own. They can help other members who are not as far along on their path, which can help improve self-esteem and give them the feeling of making a positive contribution.

However, individuals who are survivors of multi-abuse trauma do have some special safety and access concerns. Support groups should have a non-judgmental atmosphere, clear ground rules addressing confidentiality, and respect among group members.

In this section, you will find some tips, general guidelines and a sample overall support group format. We have included some suggested group topics complete with handouts. Please feel free to adapt either the overall format or the topics in whatever way works for your particular setting or time constraints.

Confidentiality

Most people in support groups respect anonymity and confidentiality, but be sure to explain what these concepts mean in your particular program, especially when there are safety issues involved. To ensure confidentiality:

- Use first names only.
- Limit notes. (Document topic covered and attendance only and require a signed release of information to disclose these.)
- Advise group participants about what you are mandated to report (child welfare or adult protective services issues, suicide threats, etc.).
- Advise individuals leaving an abusive situation not to share information in a group setting if doing so could put their safety at risk.
- Some group members don't want to be greeted or acknowledged outside of the group

due to safety or privacy concerns. Be sure to address this with the group. Some groups come up with a code to use if they see each other in a public place.

Promoting easy access to the group

Some initial discomfort is normal for anyone who is new to support groups. It is natural to feel nervous in a roomful of strangers. First-time participants may have spent years avoiding the issues the group is discussing. People whose experience includes violence or abuse also may have safety concerns. Here are some tips to help group members feel comfortable, stay safe – and hopefully, keep coming back:

- Have easy access to the group – don't create barriers. For example, try to hold the group in a location that is close to a bus stop during hours the buses are running.
- There is no right way to conduct these groups. Be open to suggestions from participants.
- Prioritize child care.
- Have healthy food, de-caffeinated coffee and tea available.
- Assist with transportation.
- Ensure accessibility for people with disabilities.
- Don't screen out. Prepare for arrival!
- Have enough staff or volunteers available to deal with unexpected issues.
- Have group members create their own resource book of referrals.

General tips

It is extremely important for facilitators to provide a safe, non-judgmental environment for people coping with multiple issues. It is also very important for facilitators to emphasize that no one deserves violence, bullying or other abuse, no matter what else is going on. Offenders should always be held solely accountable for the abuse they have directed toward their victims.

Here are some general tips for effective “drop in” support groups:

- Support group facilitators need to be trained about the unique problems faced by people who are survivors of multi-abuse trauma.

A GROUP SURVIVORS LOOK FORWARD TO

Perks such as child-care, sharing a meal together and even acupuncture help draw participants to support group sessions at South Peninsula Haven House in Homer, AK. The shelter offers support group sessions twice weekly, on Tuesdays and Thursdays. The Tuesday group addresses healthy relationships, while the Thursday group focuses on safety and sobriety.

Participants in the Tuesday night group share a meal prior to group sessions, and child-care is provided. Both shelter residents and women coming to the group from outside the shelter are welcome to come to dinner.

A community volunteer offers free acupuncture sessions prior to both the Tuesday and Thursday groups. “This lady has been doing it for over 20 years and she’s absolutely amazing. She does it out of the kindness of her heart,” says shelter coordinator Paula Lee. “I find the acupuncture really helpful. It helps with anxiety, detoxing, stress of course, and it’s just all-around healing.”

Group participants also keep a phone list for support between meetings. “A woman might need help going to court and doesn’t want to go by herself and there’s not an advocate to go,” says Ms. Lee. “She might need help moving to a safe place. She might need a babysitter. They help each other.”

- Be flexible. Think kitchen-table – have a topic in mind but be willing to change. Let members of the group own the group.
- Include time for group members to address practical issues such as housing, employment, legal or children’s issues, and community resources.
- Allow group participants to use the copy machine, telephone, fax, etc., if feasible.
- Adjust group guidelines and topics depending on setting (domestic violence shelter, sexual assault program, substance abuse treatment center, mental health facility, transitional housing program, jail or prison, or elsewhere).
- Be willing to talk about issues the group wants to talk about, but don’t pressure anyone to share if they’re not ready. “Stay away from pressuring people, because you can do a lot of damage,” says Gene Brodland, a licensed clinical social worker at the Southern Illinois University School of Medicine. If someone needs to talk about an issue, but doesn’t want to do so in front of the group, offer to talk with them individually (Brodland, 2010).
- Remember you may only see a group member once or you may have the member for

three or more years. Be solution-based and friendly, but make the most of your interaction because it may be the only one you get.

- For drop-in groups, the average member comes about 12 times; make sure all group participants understand they are welcome to return at any time.

Stage 2 groups

Typical domestic violence/sexual assault programs offer short-term group options from 4 to 12 weeks and discourage long-term presence in groups, which may be viewed as fostering dependency. Generally speaking, however, it can take twice as long for survivors of multiple abuses to do half as much as they would like to achieve because of all the barriers and challenges they face daily.

During the process of addressing multiple issues survivors continue to need emotional and other forms of safety, validation and connection, particularly when they are exhausted and overwhelmed by the many ongoing challenges they face. Providing long-term group support is an affordable option that reduces isolation, provides encouragement and fosters connection.

Stage 2 groups for survivors who have moved beyond immediate crisis but still benefit from peer group support can be led by members themselves. This is very empowering and a good option for long-term group members who are developing confidence and leadership skills. The Stage 2 group model acknowledges both the strengths of survivors of domestic violence and sexual assault and their often long-term need for peer support and encouragement.

General goals

Regardless of topic or setting, keep these overall goals for the group in mind:

- Address safety concerns and provide safe space. Participants in the group need to feel safe in order to tell their story and benefit from being believed. Be sure to *listen* and validate each person's experience, strength and hope.
- Build on existing strengths. Don't focus on what is wrong with people. Focus on what has happened to them. Provide practical support. Help group participants identify safer coping mechanisms than alcohol or drugs, cutting, binging and purging, etc., if their coping tools are not working well for them or pose risk to themselves or others.
- Provide an opportunity for connection. Encourage group members to support each other, and develop phone lists when it is safe to do so.

Overall format for groups

Participants in support groups may be more comfortable when group sessions have a predictable structure. Here is an example of an overall format that has been used successfully with people who have multiple issues including current interpersonal violence or past trauma.

- **Check in.** Open the session by asking group members to briefly state one thing they did right, or were proud of achieving during the previous week.
- **Identification of problems, challenges or goals, and resources.** Ask participants if anyone is facing a special challenge, or has a particular goal they would like to achieve. Identify resources currently utilized by group members and develop additional options to resolve problems, meet challenges and achieve goals.
- **Educational component.** Use a portion of the session to educate participants about some aspect of interpersonal violence and its relation to past trauma, mental health concerns, substance use or any of the other issues they may be facing. Topics may include power and control dynamics, safety issues, sobriety issues, wellness issues, children's issues, healthy boundaries, coping skills, etc. Below are some examples of possible topics, along with suggestions about how to use the handouts we've included in this kit.
- **Closure.** Close the session by asking individuals to name one thing they can do to achieve safety, sobriety, wellness or empowerment as defined by each person.

Sample topics for educational component and suggested handouts

Here are some sample topics for use in the educational component of support groups, along with suggestions for handouts to use with each topic. Each of these topics could stand alone, so that individuals who only attend some group sessions won't need to rely on information from a previous session to understand the topic being discussed in the current one. The topics may be used in any order. These are examples only! Nothing here is carved in stone – feel free to be creative with these topics and come up with some of your own.

Note about copyright: Group facilitators are free to photocopy as many of the handouts as they wish for educational use. However, please make sure the copyright notices appear on each of the handouts. We also request that the handouts not be altered in any way, especially the Power and Control Wheels. Please note that the Power and Control Wheels appear here courtesy of the National Center on Domestic and Sexual Violence, which credits the Domestic Abuse Intervention Project in Duluth, MN, for inspiring the wheels.

Topic: Multiple Layers of Trauma

Explain the concept of multi-abuse trauma. Give examples of *active abuse* and *coping abuse*, and discuss how these different forms of abuse interact with each other to make safety, sobriety and wellness more difficult to achieve. Explain how co-occurring issues such as mental illness or disabilities can make the situation more complex, and discuss ways the social services system and other systems may further traumatize individuals.

Use the “10 Tons of Trouble” exercises to help group participants identify overlapping elements of active abuse and coping abuse, and discuss other issues that impact safety, sobriety and wellness.

The Power and Control Wheels can be helpful for illustrating the abuses of power often involved in multi-abuse trauma.

Handouts

Multiple Layers of Trauma

Trauma: The Common Denominator

Multiple Layers of Trauma Graphic

1+1=10 Tons of Trouble

Other Issues: What Else Impacts Safety and Sobriety?

Instruction Sheet for 10 Tons of Trouble Exercise

Abuses Endured by a Woman During Her Life Cycle (Wheel)

Topic: Examples of Abuse

Discuss the different types of abuse that can happen to people with multi-abuse trauma issues. Examples include domestic violence, sexual assault or sexual abuse, child abuse, societal abuse and oppression based on gender, race or ethnic group, disability status, sexual orientation, etc. Explore some of the common elements of these different types of abuse. Example of common elements may include physical abuse, psychological abuse, sexual abuse, spiritual abuse, economic or financial abuse, use of privilege by a dominant group, etc.

Handouts

Examples of Abuse

Manifestations of Violence

Power and Control Wheel for Women’s Substance Abuse

Gay, Lesbian, Bisexual and Trans: Power and Control (Wheel)

People with Disabilities and Their Caregivers: Power and Control (Wheel)

Violence Against Native Women (Wheel)

Immigrant Power and Control (Wheel)

Topic: The Relationship Between Substance Abuse and Violence

Use the handouts “Woman Abuse/Substance Abuse” and “Survivors of Chemical Dependence, Domestic Violence and Sexual Assault” to discuss commonly-asked questions about the relationship between substance abuse and interpersonal violence. Does substance abuse cause a perpetrator to commit domestic violence or sexual assault? Will treatment stop the violence? If the victim abuses alcohol or drugs, does this mean the individual was asking for trouble?

Use the handout “Sorting Out Messages” to help those who are using services from both victim’s advocates and substance abuse counselors reconcile messages that seem to conflict or contradict each other. Key to this, for both group facilitators and participants, may be understanding that substance abuse and violence are different problems requiring different approaches.

Discuss overlapping elements of abuse and addiction using the “Merry-Go-Round of Violence” and “Merry-Go-Round of Addiction” handouts. Finally, discuss why it is usually necessary to address both substance abuse and victimization if both are part of an individual’s experience.

Handouts

Women Abuse/Substance Abuse: What is the Relationship?

Domestic Violence, Sexual Assault and Substance Use

Sorting Out Messages

Merry-Go-Round of Addiction

Merry-Go-Round of Violence

Instruction Sheet for Merry-Go-Round Exercise

Power and Control Wheel for Women’s Substance Abuse

Topic: Healing on Multiple Levels

Tia M. Holley, ANDVSA statewide training team member, created “Stages of Addiction, Stages of Untreated Trauma,” a “dip chart” or “Likert scale” to show the parallel paths that untreated trauma and untreated addictions follow. In early recovery feelings begin to emerge and emotional numbing dissipates. If the multidimensional issues are not addressed concurrently there is a high risk of relapse because the emerging overwhelming emotions push the person back to the bottom of the vicious cycle.

On the upside is how healing on multiple dimensions; body, mind, spirit, and emotional levels can help survivors get beyond the [vicious cycle](#) of pain.

The three-dimensional treatment originally addressed with this scale was the combined strengths of providing integrated Traditional healing, mental health services and addiction treatment. The three-dimensional coping skills are mental, physical and spiritual.

Use this chart to discuss the multiple levels in which the “active abuses” and “coping abuses” of multi-abuse trauma occur, and the multiple levels in which healing can happen.

Handout

Stages of Addiction, Stages of Untreated Trauma

Topic: Using Support Groups

People attending support groups together can serve as a safety net of caring individuals. Those facing similar struggles can reduce isolation, anxiety and fear through their connection with each other. However, individuals facing interpersonal violence may need to do the same kind of safety planning when they use support groups as they do when going to work, visiting relatives or using public transportation. Because of the difficulties many survivors of abuse have with boundary issues, they may also need some extra assurance that they have the right to protect their boundaries when in groups.

Discuss ways to interpret popular 12 Step concepts so they can be used in a way that is appropriate for people who have survived violence or abuse, or who have mental health issues. The handout “Using 12 Step Groups” makes numerous references to the *Big Book* of Alcoholics Anonymous and *The Twelve Steps and Twelve Traditions*, with page numbers, to provide support for people who use 12 Step groups and wish to use the suggested interpretations in that handout. Encourage participants who use 12 Step groups to discuss their own ways of interpreting the Steps as well.

In addition to 12-Step groups, other types of peer-led support groups are available in many communities to address a variety of issues. Make sure group members are aware of any of these groups that exist in your community.

Handouts

Ending Isolation: Reducing Anxiety Through Connection

Safety at Community Support Group Meetings

Etiquette in Groups

Using 12 Step Groups

Community Peer Support Groups

Topic: Who Can We Trust?

To have healthy relationships and function in the world, we all need to be able to trust somebody. However, past experiences with interpersonal violence and other trauma may have made this difficult. Discuss some of these experiences, and how they might impact a person’s ability to trust others – including advocates, counselors and other service providers, as well as spiritual leaders, institutions and authority figures.

Also explore how legitimate ideas such as spiritual traditions, constructive criticism and

legitimate authority can be twisted and distorted by abusers to justify violence and other abuse. Discuss how we determine who is trustworthy and who is not, and point out that it's perfectly appropriate to have people earn our trust.

Handouts

Trust Isn't Always Easy

Constructive vs. Abusive Criticism

Legitimate vs. Abusive Uses of Authority

Topic: Sorting Out Messages

People with multi-abuse trauma issues may be receiving services from several different providers. For example, they may be seeing an advocate for domestic violence, sexual assault or stalking, a treatment counselor for substance abuse or dependence, a therapist or psychiatrist for mental health concerns, and a social worker for assistance finding housing if they are homeless. In the process, people experiencing multiple issues may begin to acquire multiple labels. People receiving help from a variety of sources may also hear messages that seem to conflict or contradict each other. In the skit, "*Mary Has All Kinds of Troubles*," ask for several volunteers to play the part of the "helping professionals," the part of "Mary" (the person seeking services) and the part of a volunteer who will tape labels on Mary while the helping professionals are speaking. Following this role-play exercise, use the skit and the other handouts to discuss how group members can better navigate conflicting systems and advice, as well as the pros and cons of using labels.

Note: You will need to do some advance planning for this group. For each role, you may want to use a highlighting pen to highlight each actor's part in their copy of the script to make it easier to follow. (For example, you will highlight the substance abuse counselor's part in the copy of the script that you give to the person playing the role of the substance abuse counselor, Mary's part in the copy you give to Mary, etc.) Review the script and write assorted labels such as *victim*, *drug addict*, *borderline*, etc., on several sheets of 8 ½ X 11 paper. These can be taped on Mary by the volunteer while the "helping professionals" are verbally labeling this individual. Once you make up your labels, you may want to laminate them for future use.

Handouts

Skit: Mary Has All Kinds of Troubles

Sorting Out Messages

To Label or Not to Label?

Topic: Normal vs. Healthy

"Normal" simply means "the norm." People who grew up in an abusive or violent environment may have gotten a number of distorted messages about what constitutes "normal" behavior and attitudes in relationships. Skewed messages from our larger

society compound the problem – behaviors and attitudes promoted by popular culture as “normal” or desirable may be anything but healthy. Discuss the difference between “normal” and healthy, and encourage group members to question what they may have learned from both their upbringing and society about relationships. Some of the Power and Control Wheels included in this manual may be useful to illustrate the difference between healthy and unhealthy relationships. For example, contrast the Power and Control Wheel with the Equality Wheel, or the Natural Life-Supporting Power Wheel.

Handouts

Power and Control Wheel

Equality Wheel

Natural Life-Supporting Power Wheel

Topic: Healthy Relationships

Naomi Michalsen, executive director of Women In Safe Homes in Ketchikan, AK, shares an exercise she uses to facilitate group discussion of healthy relationships:

Have group participants describe the qualities their ideal partner would have, with the proviso that “it can’t be lots of money or material things like a nice car. It has to be qualities.” Ideal qualities might include such things as “a good listener” or “trustworthy” or “willing to compromise.” As participants name positive qualities, write them down on a list. Often, Ms. Michalsen says, “They’ll have honesty, respect, all the things on the Equality Wheel. They came up with it themselves. Those are the tribal values. We already have all these things in our head, but we just don’t know how to do that.”

Once group participants have come up with all the good qualities they can think of, pick a different-colored marker, and have them come up with the opposite. What’s the opposite of respect? What’s the opposite of a good listener? “And those are all the warning signs,” Ms. Michalsen says. “Or the power and control.”

Supplies

News print paper and markers

Power and Control Wheel

Equality Wheel

Topic: Getting Help

Discuss the services offered by domestic violence/sexual assault programs, mental health professionals, substance abuse treatment providers, health care providers, organizations that assist people with disabilities, indigenous providers, etc., with an emphasis on resources within your own community. Invite some of these providers to make a presentation, explain their services and answer questions from group participants.

Advocates and other providers will want to have addresses and phone numbers handy so they can make appropriate referrals, but also ask group participants to share information about resources they are aware of. Some groups have developed their own resource books to serve as an ongoing guide for both themselves and those who will follow. The books can be decorated with artwork to add a personal touch. Group participants may also want to add personal written comments about their experiences with various community resources they've used.

Handouts/Supplies

Worksheet: Where Can I Get Help?

We Are Our Own Best Advocates

Continuum of Caring: Community Based Resources for Battered Women (Wheel)

Brochures/meeting schedules from agencies/support groups in your community

Loose leaf notebooks/other supplies if group is creating resource book for the first time

Topic: Safety Planning

Advocates for victims of domestic violence encourage the people they serve to develop a safety plan. However, “safety” can mean different things for different people. For people with multiple issues, safety, sobriety, wellness and accessibility may all need to be priorities. Ask group participants to identify which issues they are dealing with and discuss what would help them feel safe.

Discuss how safety plans can be modified to include addiction recovery, mental health concerns, accessibility for people with disabilities, or other concerns. Also point out that group participants can ask their advocates or counselors to assist them individually in modifying their personalized safety plans to include those additional problems they may be facing, such as mental health issues, or substance abuse/addiction.

Mental health providers, substance abuse counselors, disabilities advocates and other providers may also help the people they serve develop treatment plans, recovery plans, or other types of service plans. Brainstorm ways to incorporate safety issues into the plans created by these other providers, and encourage group participants to discuss safety with the various providers from whom they receive services.

Note: In a residential setting, this exercise can help group participants gain understanding or empathy about additional barriers their peers may be dealing with.

Handouts

Personalized Safety Plan

Mini-Safety/Sobriety/Wellness Plan (With Instructions for Use)

What Does Safety Mean?

Topic: Power and Control Dynamics

Judith Herman, M.D., author of the book *Trauma and Recovery*, emphasizes that most interpersonal trauma is embedded in a social structure that permits the abuse and exploitation of people in subordinate groups. Use Power and Control Wheels to illustrate all the various ways that power is used and abused – both in our society and in our personal relationships – to dominate and control others.

In addition to educating about interpersonal violence, the wheels can be useful for exploring issues such as mental health concerns, substance use disorders, disability issues and various kinds of social oppression, with an eye toward ways that power dynamics can impact an individual's ability to address these issues. The Wheels can also be used to explore the use and abuse of power in various settings ranging from intimate relationships to schools, social service agencies, other institutional settings and communities.

Use the “equality” wheels and community collaboration and accountability wheels as a basis for discussion of ideal behaviors and responses in personal relationships, institutions and the community.

Handouts

Power and Control Wheel

Abuse of Children

Children Coping With Family Violence Wheel

Power and Control Model For Women's Substance Abuse

Mental Health System Power and Control: Escalating Danger

Medical Power and Control

People with Disabilities and Their Caregivers: Power and Control

Gay, Lesbian, Bisexual and Trans: Power and Control

Immigrant Power and Control Wheel

Power and Control Wheel for Women Involved in Street Prostitution

Violence Against Native Women: Battering

Bullying Power and Control Wheel

Power and Control in Dating Relationships

Abuses Endured By A Woman During Her Life Cycle

Equality Wheel

Nurturing Children

Mental Health System Power and Control: Empowerment

People with Disabilities and Their Caregivers: Equality

Natural Life-Supporting Power Wheel

Ideal Institutional Response

Topic: Parenting and Children's Issues

Children may not talk about problems they witness in the home, so it can be tempting to think they don't notice what's going on, or that it doesn't affect them that much. But

research tells a different story. Help group participants to recognize the impact of both substance abuse and violence on their children, and discuss how to create a more positive environment for children.

Handouts

Children Exposed to Domestic Violence and Substance Abuse

Abuse of Children (Wheel)

Children Coping With Family Violence (Wheel)

Nurturing Children (Wheel)

Safety Planning Interventions for Children

Topic: Working for Change

Many people who have survived trauma, especially that caused by interpersonal violence or social injustice and oppression, find that working for social change aids their own healing process. People may call their efforts working for change, service to others, or carrying the message. Discuss contributions from a variety of social movements – the women’s movement, the recovery movement, the mental health movement, the disability rights movement and civil rights movement – that have made it easier for people to get help with problems often denied or stigmatized.

Also discuss simple things group participants might do to make a difference in society while maintaining their own safety. In a group setting, choosing an activity to do together as a group (such as writing letters to elected officials regarding an issue that concerns them) may be an effective hands-on way to engage participants in the art of “making a difference.”

Handouts

Can One Person Make a Difference?

Writing a Letter That Gets Attention

Topic: Messages from Society

Naomi Michalsen, executive director of Women In Safe Homes in Ketchikan, AK, shares a group exercise she uses to help people understand social attitudes and their impact on the personal level. Make a list of a couple dozen or so behaviors and attitudes often seen in our society, or in movies or on television. Some examples may include:

A coach telling boys, “You’re playing like a bunch of girls.”

Assuming that girls are not as smart as boys at math.

Insisting that a woman’s place is in the home.

Mud flaps on a truck with the woman’s silhouette.

A billboard that says, “Come see hot young chicks” and has pictures of baby chickens.

Ads or movies or television shows with violent themes or imagery.

Your partner calls frequently or drives by your house to check if you’re home.

Being forced to have sex by someone you know on a date.
Rape/sexual assault by a stranger.

For each attitude or behavior on the list, ask, “Is this harmful?” When the group has discussed whether a particular item is harmful or relatively harmless, point out how things that may seem harmless or even funny can chip away at the value that society gives women, or can build tolerance for violence and abuse.

For this session, bring poster boards and a variety of old magazines that can be cut up – women’s magazines, sports magazines, news magazines, publications geared toward adolescents, etc. Have group participants look through the magazines for ads that promote unhealthy attitudes or behavior. Examples might include ads promoting the idea that women exist only to please men, or the idea that drinking alcohol or smoking cigarettes makes one look glamorous. Group participants may want to cut out the ads and make a collage.

Supplies

News print paper and markers

Poster board

A variety of magazines to cut up

Topic: Sharing Personal Experience, Strength and Hope

The handout “Women Talk About Substance Abuse and Violence” is based on a series of interviews with 10 women. All 10 had experienced some form of abuse: battering, rape or sexual assault, incest or child sexual abuse. In addition to the violence, all of them had experience with alcohol or drug abuse, either on their own part, on the part of their partner, or both. At the time of the interviews, all of the women had left their abusive relationships, and those with chemical dependency problems were in recovery. They talked frankly about the impact of the substance abuse on their efforts to escape the violence and heal from abuse. They also discussed how their experiences with violence affected their efforts to recover from alcoholism or other drug addiction. Ask participants to take turns reading the parts aloud. Pause between questions on the handout for comments from participants.

If you know people in the community who have successfully transcended multi-abuse trauma, you may also want to invite them to share their experiences with the group and, if they are comfortable doing so, answer questions from group members. Listening to someone who has been successful in resolving issues that group members are struggling with usually elicits a strong response.

Handout

Women Talk About Substance Abuse and Violence



HANDOUTS

AND

WHEELS

HANDOUTS

Included here are several handouts suitable for use in support groups, community education and interdisciplinary cross-training. Feel free to photocopy as many of these handouts as you wish for educational use. However, please make sure the copyright notices appear on each of the handouts. We also request that the handouts not be altered in any way.

Multiple Layers of Trauma

Multi-abuse trauma is a term used when a person is impacted by several co-occurring issues that negatively affect safety, health or well-being.

Examples of issues that negatively affect safety, health or wellbeing

- Sexual assault
- Childhood sexual abuse
- Child abuse or neglect
- Poverty
- Domestic violence
- Witnessing violence
- Substance use disorders
- Incarceration
- Homelessness
- Societal oppression
- Intergeneration grief
- Historical trauma

Multi-abuse trauma often involves both *active* forms of abuse and *coping* forms of abuse. *Active* abuse includes the kinds of harm that one human being does to another. *Coping* abuses are the methods that victims of active abuse may use to cope with their situation.

Examples of Active Abuse

Sexual assault
Domestic violence
Child abuse or neglect
Emotional or psychological abuse

Examples of Coping Abuse

Substance abuse
Compulsive eating/binging and purging
Self-mutilation (cutting)
Compulsive spending

Co-occurring issues

A survivor's situation may be further exacerbated by co-occurring barriers stemming from experiences such as poverty, medical issues, disabilities or mental health concerns. These issues may or may not be a direct result of trauma, but often complicate efforts to address it.

Another layer of trauma: Societal Abuse and Oppression

An additional layer of trauma may further complicate the situation for people who are survivors of multi-abuse trauma. In addition to the stigma surrounding issues such as a substance use disorder or psychiatric illness, they may face societal oppression due to racism, classism, ableism, heterosexism and other forms of discrimination.

Still more trauma

Coping forms of abuse may lead to further traumatic experiences, such as homelessness or incarceration, and may include the development of long-term consequences for the individual's children as well.

Yet another layer: Trauma from the system

People with multiple issues often face considerable barriers when trying to get help. Inability to access appropriate services creates its own stress. The system itself often traumatizes people with multiple issues, and adds to their problems.

Trauma: A Common Denominator

Trauma is often the common thread running through a variety of co-occurring issues, ranging from mental health concerns to substance abuse, poverty, exploitation by the sex industry, homelessness and incarceration.

A look at some statistics provides examples of how trauma is involved in many of the current issues faced by people seeking help from social service agencies, especially those who are struggling with multiple issues simultaneously:

- Preliminary data from a National Institute on Drug Abuse study noted 90 percent of women in drug treatment had experienced domestic violence from a partner during their lifetime (Miller, 1994). As many as 74 percent of women in substance abuse treatment have experienced sexual abuse (Kubbs, 2000).
- As many as 90 percent of people who have severe mental illness are survivors of at least one incident of trauma during their lifetimes (Akers et. al., 2007). Studies have found that up to 53 percent of people who seek services from public mental health centers report childhood sexual or physical abuse (Huckshorn, 2004). In one study, of the 90 percent of people receiving public mental health services who had been exposed to trauma, most had multiple experiences of trauma (Huckshorn, 2004).
- A person with a disability – regardless of age, socioeconomic status, race, ethnicity or sexual orientation – is twice as likely to be a victim of abuse than a person without a disability (Wayne State University, 2002). Among adults with developmental disabilities, as many as 83 percent of women and 32 percent of men have been victims of sexual assault (ICASA, 2001).
- In addition to abuse by family members or intimate partners, people with disabilities are at risk for abuse by attendants or health care providers. They are also more likely to experience a longer duration of abuse than people without disabilities (Young et. al, 1997). Street crime is a more serious problem as well. Studies have shown that people with disabilities have a four to ten times higher risk of becoming crime victims than persons without disabilities (Wayne State University, 2002).
- Studies show that over 50 percent of women receiving public assistance report having experienced physical abuse at some point in their adult lives, and most of these women also report a history of physical and/or sexual abuse in childhood (Lyons, 2000).
- One study found that 92 percent of homeless women have experienced severe physical or sexual abuse at some point in their lives. Of all homeless women and children, 60 percent have been abused by age 12, and 63 percent have been victims of intimate partner violence as adults (National Network to End Domestic Violence, 2004). Among cities surveyed by the U.S. Conference of Mayors in 2003, 44 percent identified domestic violence as a primary cause of homelessness (National Network to End Domestic Violence, 2004).

- Although not all sexually abused children are recruited into commercial sex, the majority of individuals involved in the commercial sex industry have a history of sexual abuse as children, usually by several people (Farley, 2003). One study found that 66 percent of people involved in commercial sex were victims of child sexual abuse. Women who are sexually abused as children are four times more likely than women who haven't been abused to work in the commercial sex industry, while men who are sexually abused as children are eight times more likely to work in the commercial sex industry (ICASA, 2001).
- Incarcerated people have a history of trauma at much higher rates than the general population. The rate of physical or sexual abuse or violence experienced by incarcerated women, either within their families or by intimate partners, is quite high – estimates vary from 44 percent to 80 percent – compared to that reported by women in the general population – a 30 percent lifetime occurrence (O'Brien, 2002). In a study of inmates at a Midwestern state prison, 22 percent of male respondents said they had been forced to have sexual contact against their will at least once while incarcerated (ICASA, 2001).

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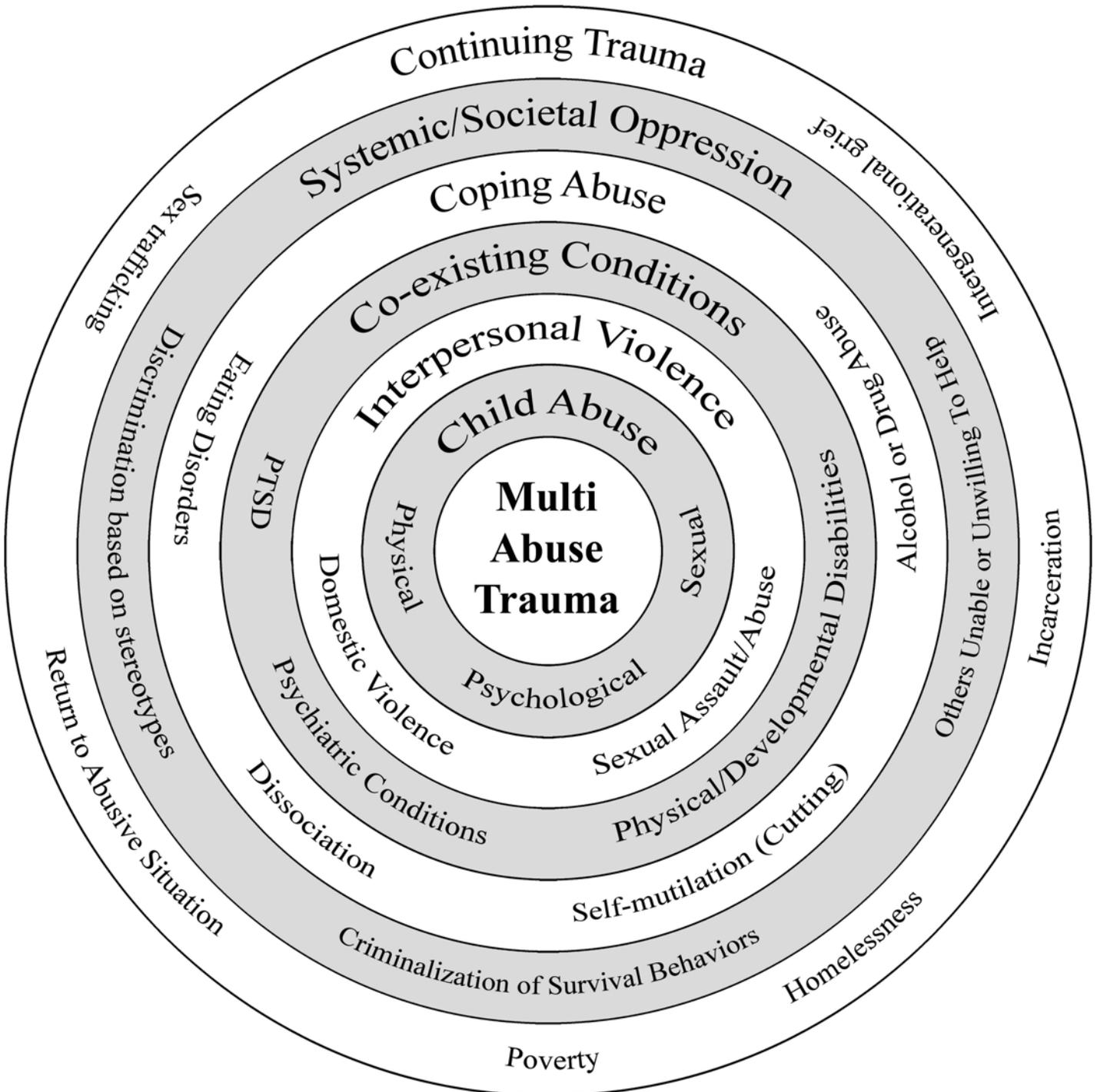
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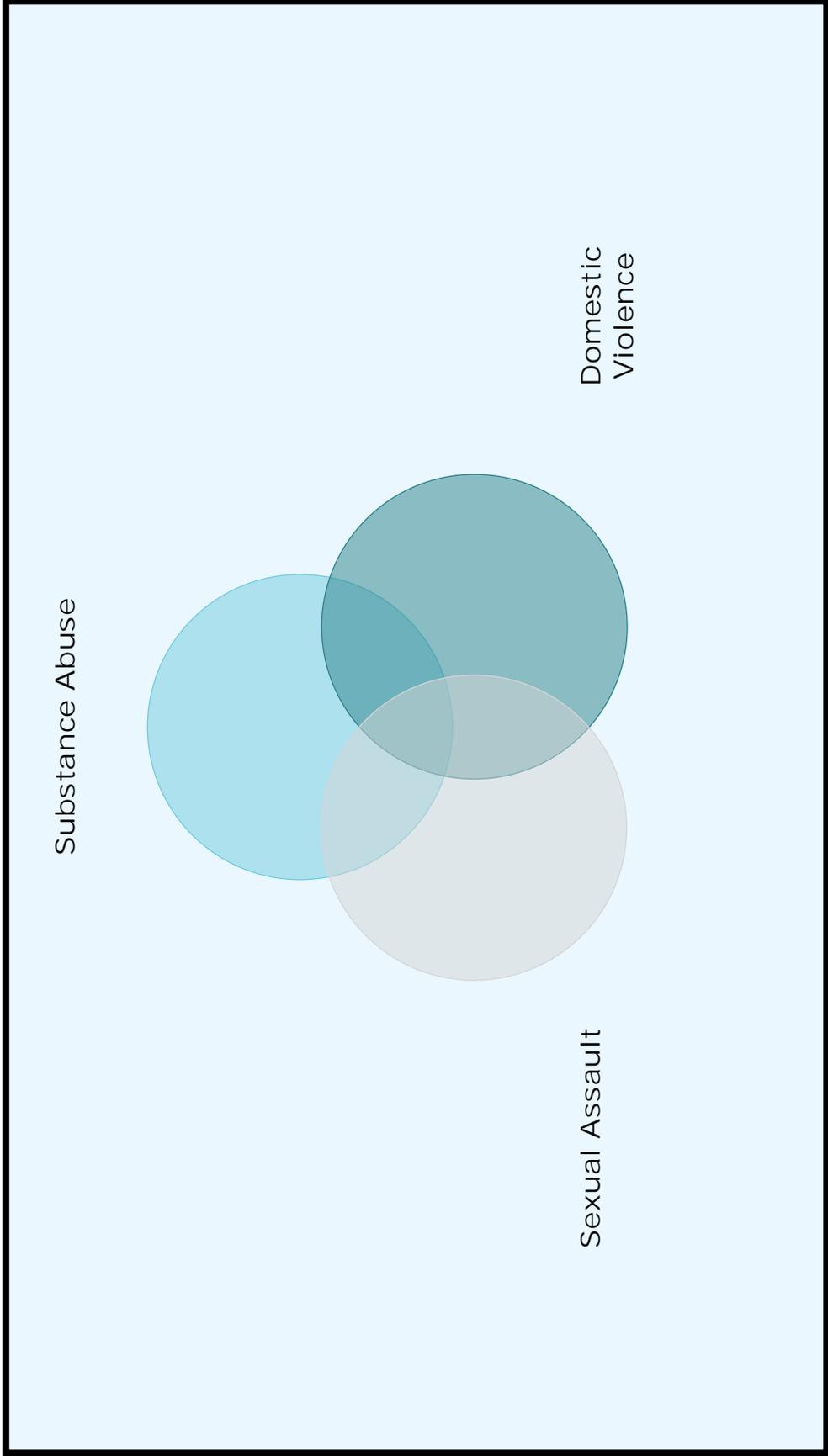
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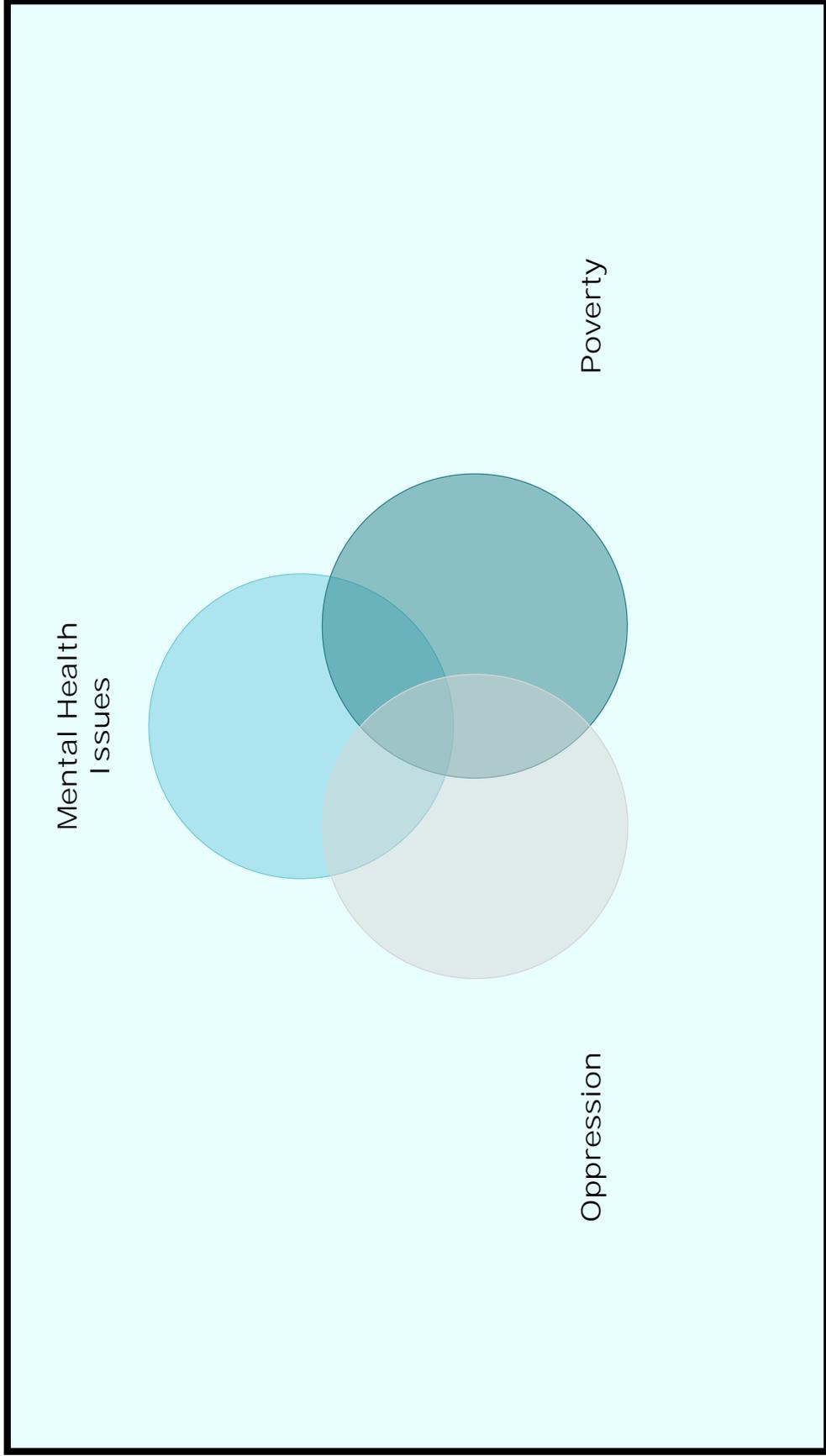
Multiple Layers of Trauma



1 + 1 = 10 Tons of Trouble



Other Issues: What Else Impacts Safety and Sobriety?



10 Tons of Trouble Exercise

Provide each group member with copies of the handouts “1 + 1 = 10 Tons of Trouble” and “Other Issues: What Else Impacts Safety and Sobriety.”

Using see-through plastic, draw and cut out a series of dinner plate sized plastic circles. Label each one with barriers and challenges individuals may face. Examples include substance abuse, sexual assault, domestic violence, poverty, homelessness, unemployment, mental health issues, oppression, intergenerational grief, historical trauma, etc. Leave a few circles blank for women to add their own challenges to.

Explain that these issues and challenges can seem like layers on an onion. As we look at one problem, many more are often revealed. Demonstrate how each problem compounds the other.

Have women identify which challenges they choose to ‘peel back’ or address first. Like peeling an onion, dealing with these challenges can cause tears.

Provide group members with additional circles. Ask the women to design circles of strength. Members can list the group itself, and add personal strengths, connections and supports that help them to survive and thrive.

Remind each woman that she possesses layers of strength, hope and connections to help her survive and thrive.

Examples of Abuse

Below are several common forms of abuse that survivors of trauma and oppression may experience – either from an abusive individual or from the larger society. Survivors may have experienced additional forms of abuse not listed here.

Physical Abuse

Shoving ... Pushing ... Slapping ... Hitting ... Pinching ... Grabbing ... Kicking ... Twisting Arms ... Pulling hair ... Choking ... Punching ... Beating ... Depriving you of sleep ... Forcing you to drink alcoholic beverages or use drugs, or “spiking” your drink without your knowledge ... Encouraging drug dependence as a way to control you ... Forcing the use of medication to sedate you

Emotional Abuse

Put-downs or ridicule Name-calling ... Yelling or screaming at you ... Humiliating you in front of others ... Not taking your concerns seriously ... Encouraging you to feel bad about yourself ... Playing mind games ... Blaming you for everything that goes wrong ... Treating you like a child ... Making decisions that affect you without consulting you

Psychological Abuse

Abusing pets ... Displaying weapons ... Destroying your belongings ... Threatening to harm you ... Threatening to take the children away from you ... Threatening suicide ... Attempting to intimidate you through looks or gestures ... Treating you like a servant ... Attempting to control access to family or friends ... Driving recklessly to frighten you

Sexual Abuse

Sexual harassment ... Rape ... Sexual assault ... Childhood sexual abuse ... Incest ... Unwanted touching ... Forcing you to watch or participate in pornography ... Pressuring you to participate in sexual activities that make you uncomfortable ... Forcing you into commercial sex ... Forcing you to have unsafe sex ... Openly having sex with others in a “monogamous” relationship ... Withholding affection or sex as punishment

Financial/Economic Abuse

Taking your money ... Not letting you have access to your own money ...
 Preventing you from getting or keeping a job ... Withholding child support ...
 Making you ask for money ... Interfering with your work or education ... Using
 your credit cards without permission ... Hiding or destroying important papers

Societal abuse

Prejudice or discrimination because of perceptions about race, gender, sexual
 orientation or other differences ... Trivializing and minimizing your experience of
 abuse ... Asking you what you did to provoke abuse ... Blaming you for violence
 committed against you ... Implying that abuse is the outcome of not knowing
 “your place” ... Ridiculing your cultural traditions or values ... Refusing to allow
 accommodations if you have a disability ... Threatening to “out” you if you are
 lesbian, gay or bisexual ... Threatening to have you deported if you have recent
 immigrant status

Spiritual Abuse

Twisting religious or spiritual teachings to justify abuse ... Ridiculing your beliefs
 ... Preventing you from practicing your religion or spiritual tradition ... Forced
 conversion to a different religion or spiritual tradition ... Discriminating against
 you because of your religious beliefs or spiritual tradition ... Forcing one
 individual’s or group’s beliefs and values on others

Manifestations of Violence

Abuse can occur in different forms. It can be physical, emotional, sexual, spiritual, social and/or economic. The lists below describe some of the tactics of abuse batterers use as they attempt to gain or maintain power and control over their intimate partners. Abuse does not always progress in regular steps as shown here. Sometimes the abuse may advance from pushing or hitting directly to more severe physical violence such as use of weapons. Although each relationship is unique, any type of abuse must be considered a serious cause for concern. Despite different circumstances, it is important to remember abuse can escalate (especially if intervention fails to occur). A coordinated community response holding batterers accountable for these abusive behaviors is essential as is a response acknowledging and respecting the rights of DV victims. **EXERCISE:** It is helpful for people to be aware of the tactics of domestic violence. Circle the type(s) of abuse you are now experiencing, (or have experienced in the past). Notice if the violence is increasing in intensity, severity or frequency. Talk to an advocate to develop or review your current safety plan or explore your options. Remember, domestic violence or sexual abuse directed at you is never your fault (even if you were drinking or using drugs).

Emotional Abuse

insulting jokes	ignore feelings	jealousy	isolation	humiliation	harming pets	calls you 'crazy', 'drunk', or 'junkie'
silent treatment	insults	blaming/accusations	monitoring activities	threats	degradation	homicide/suicide

Physical Abuse

scratch	slap	push	hit	target hit	kick	choke-hold or strangle	beat	weapon use	murder
deny physical needs	bite	force drug use	punch	throw objects	burn	sleep deprivation	poison	disablement/disfigurement	

(Manifestations of Violence, continued)

Sexual Abuse

embarrassing comments	ignore sexual needs	forced to look at pornography	sex as duty	control contraceptives	forced prostitution for drugs	forced sex soon after pregnancy	death
sexual jokes	unwanted touching	treat like sex object, 13 th step	withhold sex as punishment	demand monogamy when abuser is promiscuous	sex after violence	rape	

Social/Environmental Abuse

uses gender myths/roles	destroys property	controls major decisions	controls money or finances	threats to victim's family/friends	complete isolation	convinces victims they are hysterical/paranoid/suicidal	
degrades culture, religion, gender, profession, recovery from substance abuse, etc.		demonstration of strength	denies access to work	eliminates support system including access to health care or substance abuse treatment		child abuse/incest	suicide

Woman Abuse, Substance Abuse: What is the Relationship?

When substance abuse and violence against women happen together, many people get confused about cause and effect. Does alcohol or drug use cause a perpetrator to get violent? Does being a victim of violence cause a woman to develop substance abuse problems? If a woman abuses alcohol or drugs, does this mean she asks for trouble? Here, based on research, are answers to some commonly asked questions.

Does alcohol or drug use cause violent behavior?

Studies show that people who get violent when intoxicated already have attitudes that support violence.¹ They believe they have the right to control another person. They believe violence and other abuse are acceptable ways to gain control. A perpetrator may use intoxication to excuse violent or abusive behavior. But substance abuse is no excuse for crimes such as domestic violence or sexual assault.

Will treatment help a perpetrator stop being violent?

If a woman leaves an abusive relationship, her partner may promise to get treatment or attend A.A. meetings. These promises may be a way to manipulate her into returning. Unfortunately, there is no guarantee that substance abuse treatment will stop violence.² If physical violence stops, other abusive and controlling behavior often replaces it.² A perpetrator must confront attitudes that support violence.

Does being a victim of violence cause substance abuse?

Not every abused woman uses alcohol or drugs. So there is not a direct cause-and-effect relationship. But trauma can increase a woman's risk for substance abuse.¹ Some women may use alcohol or drugs as an anesthetic, to relieve the pain caused by violence.¹ If the pain continues, and the "self-medicating" continues, conditions are perfect for addiction to develop.

If a woman abuses alcohol or drugs, does this mean she asks for trouble?

No woman deserves to be abused in any way, *no matter what else is going on*. If she is in a relationship, does this mean her partner must overlook substance abuse? No. Her partner has a right to ask that she get counseling or other help. Her partner has a right to end the relationship. But drinking or drug use never justifies violence.

Why is substance abuse risky in a violent situation?

While substance abuse does not cause violence, it can make a violent situation more dangerous. If the perpetrator is intoxicated, there is a greater risk the victim will be injured or killed.³ If the victim is intoxicated, she may find it harder to get safe.²

Women coping with violence and their own substance abuse may find themselves caught up on a merry-go-round. Substance abuse makes it harder to escape a violent situation, or to heal from past abuse.² Continuing violence or unresolved feelings about abuse make it harder to stay away from alcohol or drugs.²

How does substance abuse interfere with safety?

Substance abuse impairs judgment. This makes safety planning more difficult.² The victim may avoid calling police for fear of getting arrested or being reported to a child welfare agency.² She may be denied access to shelters or other services if she is intoxicated.²

How does substance abuse interfere with healing from violence?

If a woman is abusing alcohol or drugs, it is hard to heal the pain caused by violence. Counseling or therapy sessions can bring out strong emotions.¹ Alcohol and drugs cut off these emotions, and the feelings get pushed back down inside.¹ So the work cannot go forward. The healing doesn't happen. The pain continues.

How does violence interfere with recovery from addiction?

A woman may use alcohol or drugs to “stuff” her feelings about the abuse.¹ When she stops drinking alcohol or using drugs, buried emotions may come to the surface.¹ These feelings of pain, fear or shame can lead to relapse if not addressed.⁴

In an abusive relationship, a woman's recovery may threaten her partner's sense of control. To regain control, her partner may try to undermine her recovery.¹ Her partner may pressure her to use alcohol or drugs.¹ Her partner may discourage her from seeing her counselor, completing treatment, or attending meetings.¹ Her partner may escalate the violence.¹

How can a woman get off this merry-go-round?

Many women have found they will need to address both the substance abuse and the violence.² A domestic violence agency can help a woman who is in an abusive relationship. A rape crisis center can help if she has been sexually assaulted or sexually abused. Substance abuse treatment can help if she has problems with alcohol or other drugs. No matter where she goes for help first, her counselor or advocate can make referrals. This way, she can get all the services she needs.

¹ Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. *Substance Abuse Treatment and Domestic Violence, Treatment Improvement Protocol Series 25*. Rockville, MD: U.S. Department of Health and Human Services, 1997

² Domestic Violence/Substance Abuse Interdisciplinary Task Force. *Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse*. Springfield, IL: Illinois Department of Human Services, 2000

³ Bland, Patricia J. Strategies for improving women's safety and sobriety. *The Source, Reprint 50*, 1997

⁴ Simmons, Katherine P., Terry Sack and Geri Miller. Sexual Abuse and Chemical Dependency: Implications for Women in Recovery. *Women and Therapy 19 (2)*, 22

SURVIVORS of CHEMICAL DEPENDENCE, DOMESTIC VIOLENCE and SEXUAL ASSAULT

By Patricia J. Bland

Keep in mind that not all people who drink or use drugs are alcoholics or addicts. When alcoholism or addiction is present there is great pain, shame, fear and isolation.

- Alcohol and drug use is associated with greater severity of injuries and increased lethality rates. However, **SUBSTANCE ABUSE DOES NOT CAUSE DOMESTIC VIOLENCE or SEXUAL ASSAULT.**
- Being identified as either an alcoholic or an addict (even if people are in recovery) can impact ability to get housing and gain or maintain child custody. This may affect careers, community standing, and/or support (or lack thereof). Increased insurance rates, and legal difficulties may also be experienced.
- Chemically dependent people face many service barriers. Shelter space is often denied, detox may not be available immediately, and treatment may seem less urgent than getting **SAFE.**
- Chemically dependent battered persons and survivors of sexual assault are not powerless. They are victims of both a life threatening disease **and** violent crime. Empowerment for these survivors involves **both** **SAFETY** and **SOBRIETY.**
- Many substance abusing victims of domestic violence and sexual assault are introduced to drugs by partners who use substances to gain and maintain power and control. A violent person may use alcohol or date rape drugs like rohypnol to more easily harm another. This is a form of physical, emotional, social, sexual and spiritual abuse. Recognizing this may help establish trust and reduce stigma.
- Substance abusing victims of violence are often victimized by substance abusing perpetrators. Cessation of drinking and drug use alone **cannot** ensure safety. Often, recovery is accompanied by more danger for victims. As victim sobriety increases perpetrators may find their ability to control their partners threatened. They may seek to sabotage recovery efforts or look for new ways to regain control. Refer people to support groups addressing both the substance abuse as well as the domestic violence/sexual assault issues.



- Treatment for substance abuse can pose many risks for victims of domestic violence/sexual assault. **Conjoint or couples counseling is not appropriate and should not be encouraged by providers.** Domestic violence/sexual assault victims in methadone programs may be particularly vulnerable because they must appear daily at a set time for their dose and thus can be easily tracked by an abuser.
- Validate that anyone might use drinking or drugging to cope but there are safer ways to survive sexism, homophobia, racism, ageism, ableism, classism, sexual assault, rape trauma, abuse, domestic violence and other forms of pain and oppression.
- Offer options but recognize substances impair judgment, making advocacy-based counseling more challenging. Don't be afraid to refer to 12-step programs, but be able to explain both strengths and limitations. Be aware of alternative referrals, especially for gender-specific or culturally appropriate support groups or chemical dependency treatment providers.
- Recognize euphoric recall and blackout make safety planning harder. Denial of use is not about fooling the provider. It's a tactic to be addressed in a respectful manner. Facing the truth is scary and painful for the alcoholic or addict. Always be honest and direct, but remember tact and dignity.
- Chemical dependency undermines both health and judgment. Withdrawal symptoms can be painful and life threatening. Encourage people to seek medical attention prior to detoxing.
- Realize, chemically affected victims of violence often believe their use of a substance means the violence directed against them is warranted. Always affirm no one has the right to hurt them, and that violence directed against them is **never their fault** under any circumstance.
- Understand both negative stereotypes and negative internal views about domestic violence, sexual assault and addiction act as barriers preventing people from realizing they need support. Additionally, service providers must examine their own beliefs about alcohol and other drug use, abuse and addiction to ensure addict phobia is not impairing their ability to effectively advocate for recovering or actively using victims of violence.
- Refer people addressing chemical dependency and interpersonal violence issues to the local domestic violence/sexual assault or substance abuse program. You may also refer them to the **Alcohol Drug Help Line Domestic Violence Outreach Project at 1-800-562-1240.**

Sorting Out Messages

If you are recovering from an addiction, you may be seeing a substance abuse counselor. If you are dealing with violence or abuse, you may be seeing a women's advocate. If you are seeing a women's advocate *and* a substance abuse counselor, you may be getting confused! These are some of the messages you may be hearing:

Substance abuse counselor: You have a disease. You need treatment.

Women's advocate: You are a victim of a crime. You need justice.

Substance abuse counselor: Your priority must be sobriety.

Women's advocate: Our priority is your safety.

Substance abuse counselor: You must accept your powerlessness.

Women's advocate: You need to be empowered.

Substance abuse counselor: You need to look for your part in your problems.

Women's advocate: You are not responsible for what happened. The perpetrator must be held accountable.

Substance abuse counselor: You need to change yourself and be of service to others.

Women's advocate: We need to change society.

Can these statements all be true? One way to reconcile the messages is to understand that substance abuse and violence are different problems. When people talk about different problems, they may need different words and different approaches. Here are some examples.

Disease or criminal behavior?

Addiction is a disease. It is not a crime. People do not choose how their bodies will respond to alcohol or drugs. People with addictions deserve treatment and recovery. Violence is a crime. It is not a disease. Perpetrators choose to commit domestic violence, sexual assault and sexual abuse. Their victims deserve justice.

Safety first or sobriety first?

For "recovering survivors," both safety and sobriety must be priorities. Women's advocates have clients develop a safety plan. Substance abuse counselors have clients develop a recovery plan. You can make recovery part of your safety plan, and safety part of your recovery plan.

Powerlessness or empowerment?

You are powerless over the impact of chemicals on your body. You are powerless over another person's behavior. But you can choose to seek help getting safe and sober. When you make personal choices, you become empowered.

Who is responsible?

You are responsible for recovery from addiction. The perpetrator is responsible for violence. You are responsible for your own choices and your own behavior. You are not responsible for another person's choices or behavior.

Social change or service to others?

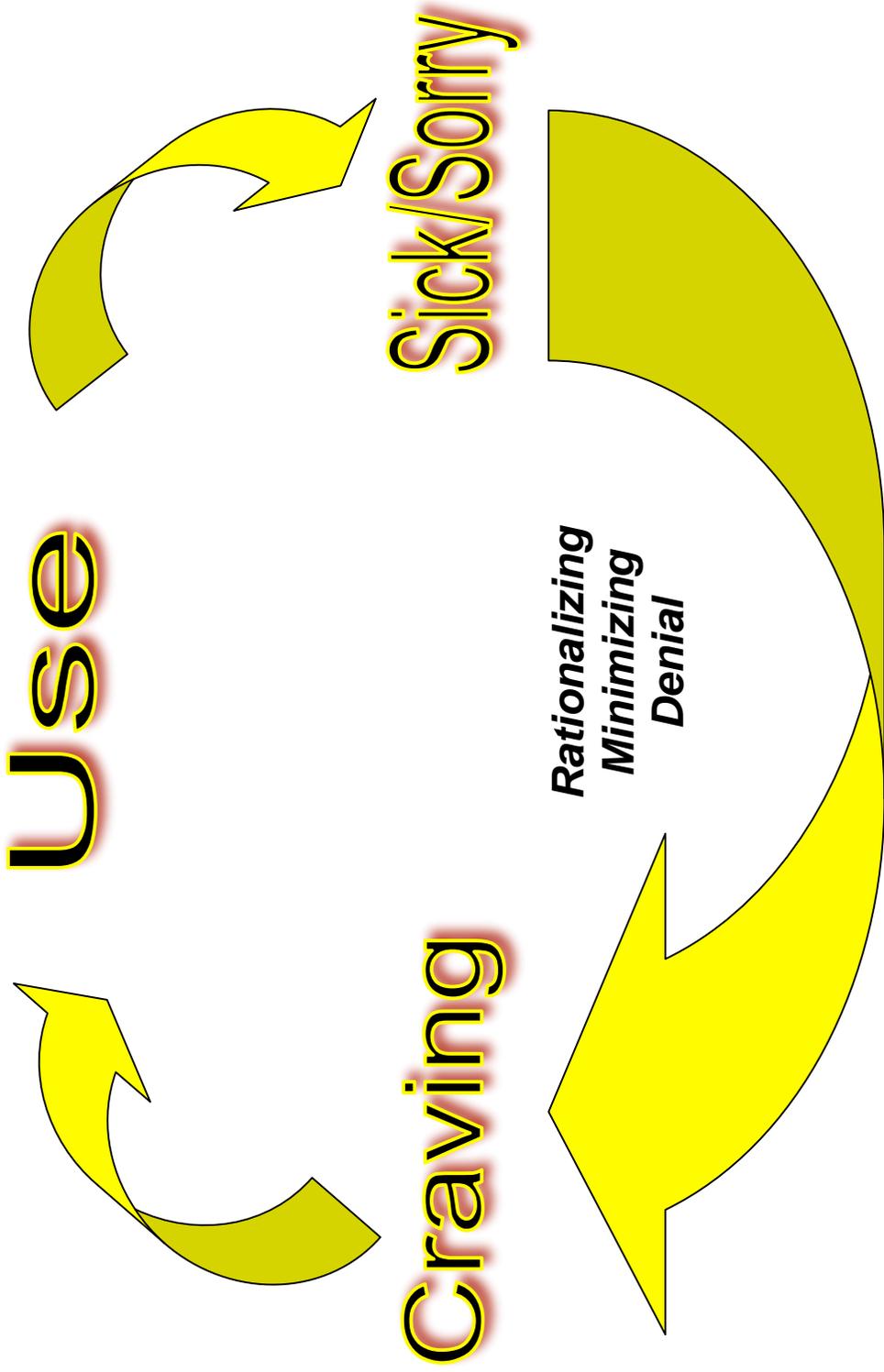
Service to others is one way to achieve social change. Working for social change can be a way to serve others. When people in 12-Step groups take a meeting to a jail or hospital, they serve others. They also create social change by making recovery available to more people. When abuse survivors make a T-shirt for the Clothesline Project, they help change public attitudes about violence. This serves other victims of violence.

Of course, sometimes the same approach *can* work for different problems. People with addictions often take a “one day at a time” approach to recovery. This approach can also work well for women leaving a violent relationship or healing from abuse. Both recovering women and abused women can benefit by getting support from others.

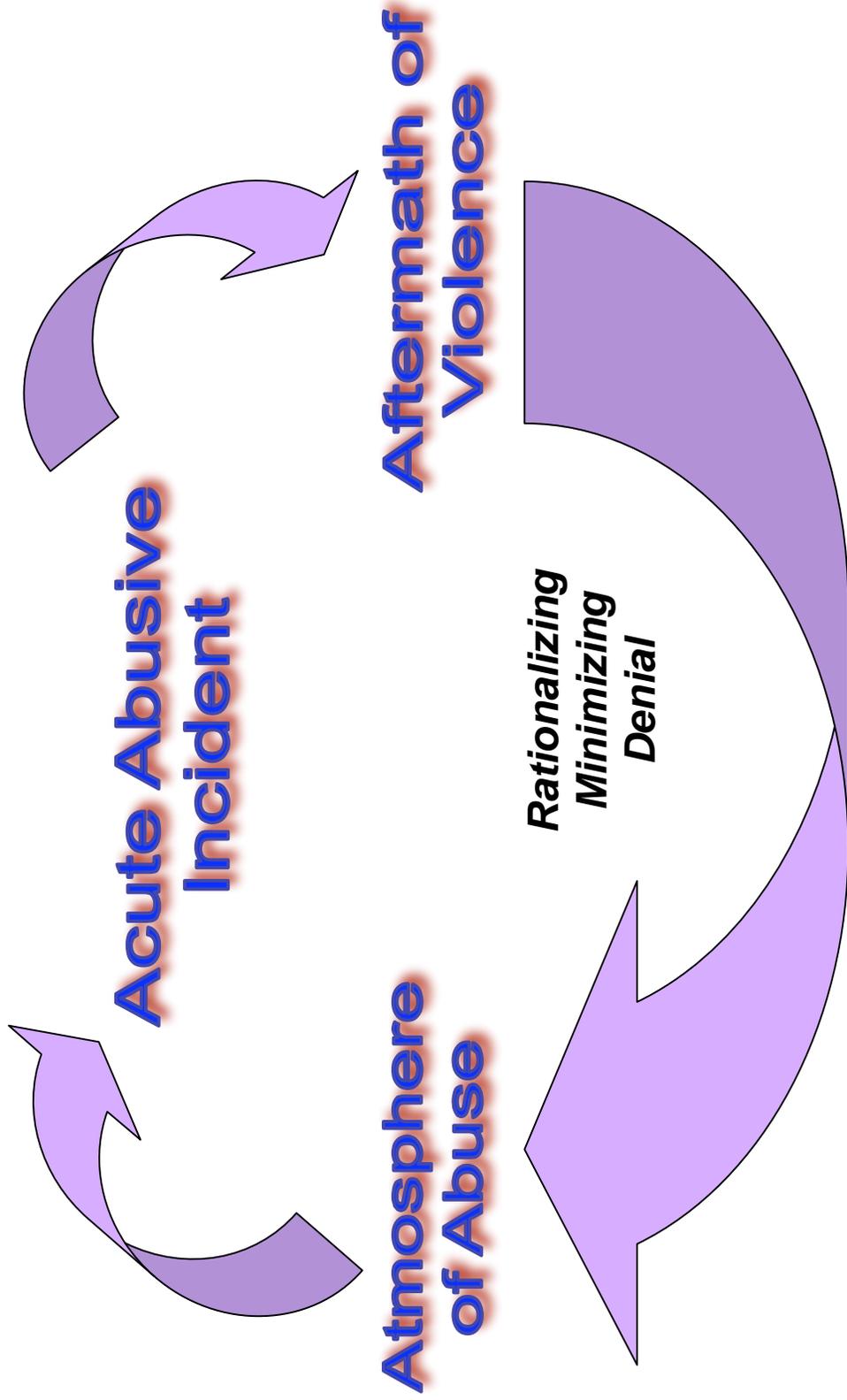
When sorting out messages from helping professionals, be creative. Give yourself permission to reconcile the messages in a way that works for you. The most important thing is that you be able to benefit from both kinds of services.

Some examples of the differing words and approaches used by women’s advocates and substance abuse counselors are adapted from *Domestic Violence and Chemical Dependency: Different Languages*, developed by Theresa Zubretsky, New York State Office for the Prevention of Domestic Violence. Available: www.thesafetyzone.org/alcohol/language.html

Merry-Go-Round of Addiction



Merry-Go-Round of Violence



INSTRUCTIONS FOR MERRY-GO-ROUND EXERCISE

Group participants discuss both Merry-Go-Rounds and compare/contrast similarities and differences. People in treatment use addiction diagram first; those in domestic violence programs use abuse diagram first.

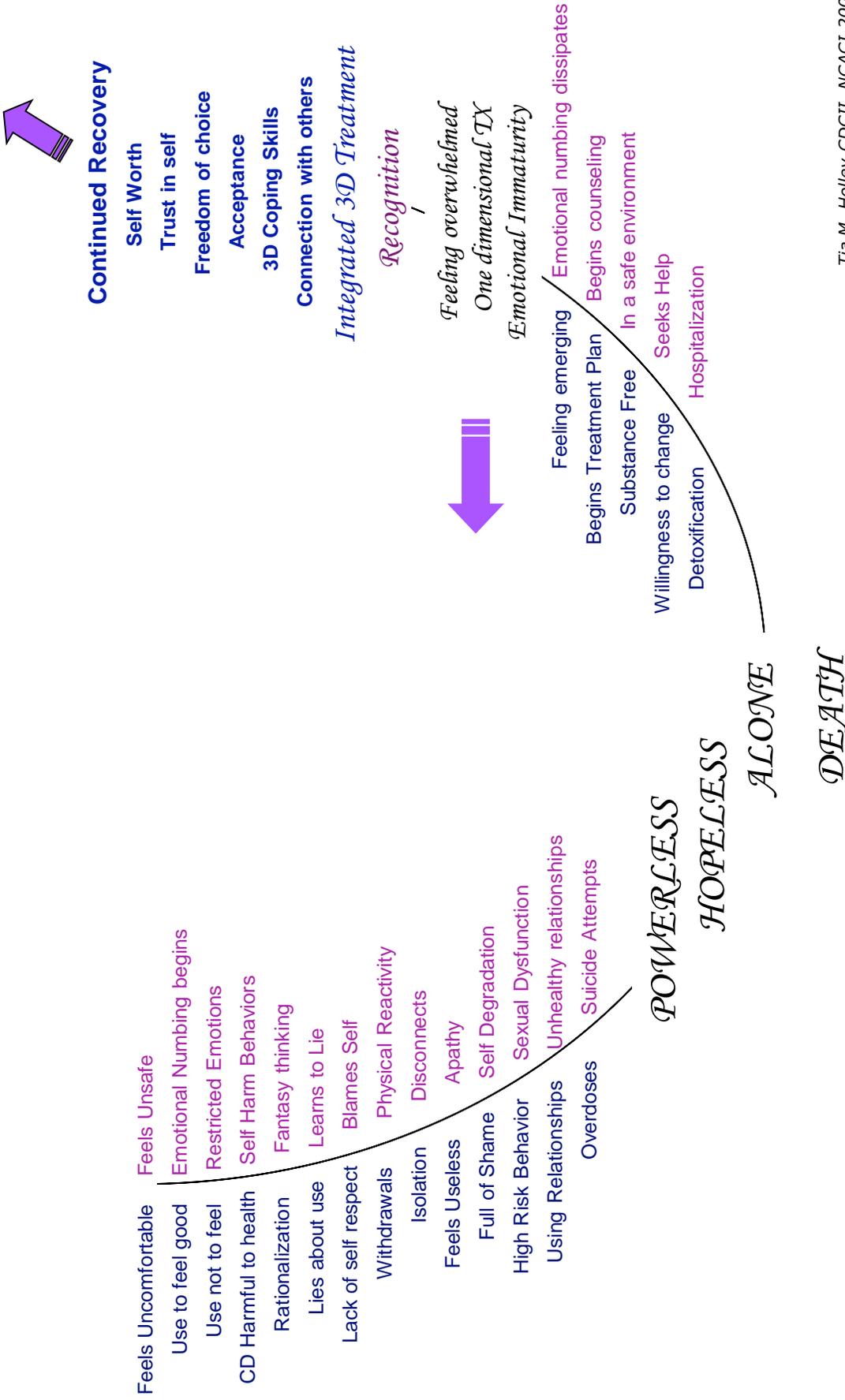
Merry-Go-Round of Addiction: Provide Merry-Go-Round diagram to group participants and draw copy on white board or flip chart. Discuss Craving, Use and Sick and Sorry with group participants. Brainstorm group responses to the questions below and write answers down on the board. Discuss role rationalizing, minimizing and denial plays to keep the merry-go-round in motion. (When discussing “Use,” it’s okay to be brief, look for initial feeling and move on to “Sick and Sorry” to avoid euphoric recall.)

When I am craving:	When I am using:	When I am sick and sorry:
How do I feel emotionally?	How do I feel emotionally?	How do I feel emotionally?
What are my thoughts?		What are my thoughts?
What do I say?		What do I say?
How do I act?		How do I act?
What do I do?		What do I do?
Where am I spiritually?		Where am I spiritually?
Where am I economically?		Where am I economically?
Where am I socially?		Where am I socially?
Where am I sexually?		Where am I sexually?

Merry-Go-Round of Abuse: Provide diagram to group participants and draw copy on board. Discuss Atmosphere of Abuse, Acute Episode and Aftermath with group. Brainstorm group responses to the questions below and record answers on the board. Discuss role rationalizing, minimizing and denial plays to keep the merry-go-round in motion. (When discussing “acute episode,” it’s okay to be brief. Graphic details may re-traumatize.)

When I live in an atmosphere of abuse:	When I experience an acute episode of abuse: Note: Abuse is pervasive. Acute abusive incident may be physical, emotional or verbal, sexual, economic or any other form of harm, coercion or threat to gain or maintain power and control.	When I live in the aftermath of violence:
How do I feel emotionally?	How do I feel emotionally?	How do I feel emotionally?
What are my thoughts?		What are my thoughts?
What do I say?		What do I say?
How do I act?		How do I act?
What do I do?		What do I do?
Where am I spiritually?		Where am I spiritually?
Where am I economically?		Where am I economically?
Where am I socially?		Where am I socially?
Where am I sexually?		Where am I sexually?

*“Stages of Addiction, Stages of Untreated Trauma” **



Ending Isolation: Reducing Anxiety through Connection

Women seeking safety, sobriety, wellness and justice face many barriers. Simple tasks can be frightening or overwhelming at times. Going to court, interacting with Children's Services or just setting foot outside can bring on fear and anxiety. This uneasiness is compounded when a person feels all alone. Women attending support groups together can serve as a safety net of caring individuals. Women facing similar struggles can reduce isolation, anxiety and fear through their connection to each other.

The women at New Beginnings Wednesday night Support Group came up with the following plan themselves. A member of the group was terrified to go to court alone. She was afraid she would have a panic attack, take a drink or crumple when she saw her abuser. None of these options felt good and she said in anguish, "If I just could take all of you with me, I wouldn't feel so all alone." Another group member said, "Maybe we could help you. We can't physically go but we could all write down a message for you and you could carry it into court with you. Then we would be with you. You would not be alone." Another group member said, "We can write down our numbers and you can call us before you go in, or if you get scared or after you leave." We can make a safety plan together," said yet another. "You can call us if you are thinking of taking a drink, feel like fainting or if your partner says or does something hurtful or scary."

That evening the women passed around a piece of paper. Everyone in the group wrote a note of support and provided phone numbers. A simple plan was formed. The next day our group member went to court but she was not alone. She had the power of the group on the paper in her pocket. She took the paper out and read, "We believe you. You can do it. We care." She used the phone numbers. She got through the day and she knew people believed her and cared for her. She said, "When I came in here I felt lower than the rug and so alone. Now I know I'm part of something bigger than myself. There's a whole movement out there made up of people just like me, and we are there for each other."

Today when any group member feels afraid, and doesn't think she can handle a court date or other event alone, group members remind her, "You are not alone." They ask for paper and pen. Sometimes they write down their words of support; other times they designate a group member to write down words of wisdom and support. It is very healing and empowering to feel safe enough to tell your story, to be believed and to feel connected. This simple tool is most useful and empowering because it is rooted in the experience, strength and hope of women like you. Do you need help from the group today? It is okay to ask for support if you need it now. Today you are not alone.

Note: Some members may choose NOT to provide a phone number if doing so is uncomfortable or poses a safety risk.

Safety at Community Support Group Meetings

Community support groups can serve as a valuable supplement to counseling or advocacy. Much of the power in these groups comes from the personal stories. People share their experience, strength and hope with each other. When one person breaks the silence about “unspeakable” experiences, especially those that carry a lot of stigma, others feel safer breaking *their* silence. You also hear success stories. You hear what others are doing to cope with problems similar to yours.

Some initial discomfort is normal if you’re new to support groups. It is natural to feel nervous in a roomful of strangers. You may have spent years avoiding the issues the group is discussing. If your experience includes violence or abuse, you also may have safety concerns. Here are some tips to help you feel comfortable — and stay safe:

- ***Protect your safety.*** Most people in support groups respect confidentiality (anonymity). However, if you are leaving an abuser, don’t share information that could put your safety at risk. Do carry your cell phone with you to 12 Step meetings or other support group meetings if you have one. Tell your sponsor or someone else at the meeting what is going on.
- ***Find a home group.*** For people who attend 12-Step groups, this is a group you attend regularly. You get to know other “regulars” and feel more comfortable talking at meetings. Some 12 Step veterans have two or three home groups. If you need to avoid being predictable to an abuser, have a back-up home group. Alternate between one meeting and the other one.
- ***Shop around.*** You will probably notice that each support group has a distinct personality, depending on who attends. For example, larger communities may have a number of different Alcoholics Anonymous groups holding meetings in a given week. Sample several. Some people feel most comfortable in small, intimate groups. Others may feel more comfortable at meetings with large numbers of people in attendance, because they can sit back and listen and feel less pressure to speak or contribute right away.
- ***Recognize the group’s limitations.*** Support group meetings are not meant to be a substitute for professional help. Use sessions with a counselor or advocate for issues that are beyond the group’s scope.
- ***Respect your own boundaries.*** Some people may try to sexually exploit others in the group. 12-Steppers call this practice “13th Stepping,” and most consider such behavior unethical. You don’t have to tolerate it! Also, don’t feel compelled to talk about painful abuse issues in groups if this makes you uncomfortable.
- ***Try “specialty” groups.*** In many communities, Alcoholics Anonymous has “Beginner’s Groups” designed for people who are new to recovery. Some women who are survivors of domestic violence or sexual abuse may have difficulty setting healthy boundaries, especially with men, and report that women-only meetings feel safer than meetings where both men and women are present. One can also find 12-Step groups especially for lesbian, gay, bisexual and transgendered people.

Etiquette in Groups

No doubt about it, early recovery can be a stressful time. The same goes for the early days when we're freeing ourselves from an abusive relationship or healing from past trauma. Our relationships with others — whether in support groups, a rehab program, a shelter, or any close living quarters — can be either a source of support or a source of additional stress. We can make things easier on both ourselves and others if we observe a few basic courtesies:

- Focus on our own issues. We avoid taking the “inventory” of others in the group or telling them what to do.
- Remember why we're here. In-house group sessions and community support group meetings are not a place to vent about a personal conflict with another individual in the group. We need to focus on our own recovery and safety — “principles before personalities.”
- Respect other people's experiences. When someone is sharing, we focus on what we can identify with or agree with, rather than focusing on our differences. “Identify, don't compare.”
- Respect other people's ideas and beliefs. We have a right to our own religious beliefs, political views and philosophies. We do not have a right to force these beliefs and ideas on others, nor do others have a right to force their views on us.
- Avoid letting another person's behavior affect our progress. If someone else wants to have a Bad Attitude Day, we can resolve to let their attitudes be “their stuff” and understand that they may be experiencing a great deal of stress.
- Welcome newcomers. We can remember how we felt when we attended our first meeting or group session, or first came into a new program.
- Help other people feel like they “belong,” rather than finding reasons to exclude them. We may remember how we felt about those snotty junior high school cliques that seemed to exclude us. We avoid inflicting this kind of pain on others.
- No 13th Stepping! (For people in 12 Step groups, 13th Stepping is the practice of using meetings to initiate romantic relationships with someone else in the group.) Meetings and group sessions are not a dating service, and “hitting on” people is not fair to those who are attending groups to work on their issues. This applies whether we are a woman or a man, gay or straight. (Note: If you are the target of a 13th Stepper, keep in mind that healthy 12 Step groups consider this behavior unethical. Feel free to speak up about it. You do not have to put up with it.)
- Avoid gossip. Avoid gossip. Avoid gossip.
- Be considerate of the needs and feelings of others in the group. The Golden Rule applies here. If we treat others the way we want to be treated, we can go a long way toward avoiding needless conflict.

Using 12 Step Groups

People recovering from addictions often participate in 12-Step groups such as Alcoholics Anonymous or Narcotics Anonymous. Many find these groups a helpful source of support. If you have experienced violence or abuse, here are some ideas to consider while “working the program.” As they say in 12 Step groups, take what you need and leave the rest.

Step One: We admitted that we were powerless over alcohol (or our addiction) — that our lives had become unmanageable.

When 12 Step groups discuss powerlessness, it may be helpful to explore how power is defined. Some people view power as the ability to control other people, places and things. “The program” asks you to let go of attempts to have this kind of power.

However, power can also be defined as the ability to make choices and act on them. For example, you cannot control the impact of chemicals on your body. But you can choose to seek treatment for an addiction. If you are in an abusive relationship, you cannot control your partner’s behavior. But you can choose to seek help getting safe.

This step encourages you to break through denial and acknowledge that you are out of control with alcohol or another addiction. Before you can do something about a problem, you must acknowledge that the problem exists.

Step Two: Came to believe that a power greater than ourselves could restore us to sanity.

Some women feel more comfortable with feminine or gender-neutral images of God or “higher power.” This may be especially true for women who have been abused by a male parent or partner. Remember that 12 Step groups encourage you to interpret “higher power” in whatever way feels right for you. A.A. literature says, “When we speak of God, we mean your own conception of God.”¹ In fact, “You can, if you wish, make A.A. itself your ‘higher power.’ Here’s a very large group of people who have solved their alcohol problem.”²

This step encourages you to feel hope. There is a way out of your problems. Help is available. Recovery and healing are possible.

Step Three: Made a decision to turn our will and our lives over to the care of God as we understood Him.

For some women, turning over our will to someone else may sound like a demand from an abuser. It may be helpful to remember that there is a difference between turning one’s will over to a deity (if that is what your religious or spiritual tradition teaches), and being asked to turn your will over to another human being.

It may also be helpful to think of “turning it over” as “letting go,” and willingness as being open to new ideas. Giving up an addiction (or a relationship) can feel pretty scary. You are letting go of something familiar without knowing what will replace it. The good news is you don’t have to do this alone.

This step encourages you to break your isolation by seeking help and accepting the support that is offered.

Step Four: Made a searching and fearless moral inventory of ourselves.

Keep in mind that Step Four is not an “immoral inventory.” A.A. literature points out that “assets can be noted with liabilities.”³ Listing your strengths can be especially helpful if your self-esteem has been battered by abuse.

A.A. literature suggests that you “consider carefully all personal relationships which bring continuous or recurring trouble. Appraising each situation fairly, can I see where I have been at fault? ... And if the actions of others are part of the cause, what can I do about that?”⁴ When looking at relationships, remember that you are not responsible for violence or abuse committed against you. However, exploring the impact abuse has had on your life can strengthen your resolve to break free of the abuse and heal from it.

This step encourages you to take a realistic look at your life. This allows you to discover your strengths and limitations, and identify your needs.

Step Five: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

When you choose someone to hear your Fifth Step, A.A. literature cautions you to “take much care.”⁵ This care is especially important if you are a survivor of domestic violence, sexual assault or sexual abuse. Survivors may want to share this part of their experience with a qualified therapist or advocate. This person should understand that responsibility for violence belongs with the perpetrator.

This step encourages you to share your past with someone you trust. This can help you let go of the shame that comes with thinking you must keep parts of your life secret.

Step Six: Were entirely ready to have God remove these defects of character.

Nobody is perfect, so self-improvement is a worthy goal for everyone. But A.A. literature cautions you to “avoid extreme judgments” and “not exaggerate” your defects.⁶ This precaution is especially important for abused women. An abuser may have whittled away at your self-esteem by encouraging you to feel defective. A person who wants to control you is not the best judge of your character!

A.A. literature also reminds you to distinguish between societal expectations and your own values. For example, when the subject is sex, “we find human opinions running to extremes — absurd extremes, perhaps.”⁷ This can certainly be said about the messages our society directs toward women. Women also get mixed messages about everything from their roles to how they should look or act. Step Six can be a good place to examine what your own values are.

This step encourages you to prepare for change in your usual patterns of behavior. What behaviors do you want to let go of? What patterns do you want to stop repeating?

Step Seven: Humbly asked Him to remove our shortcomings.

A.A. literature says humility is “a word often misunderstood. ... It amounts to a clear recognition of what and who we really are, followed by a sincere attempt to become what we could be.”⁸ We should “be sensible, tactful, considerate and humble without being servile or scraping.”⁹ And, “we stand on our feet; we don’t crawl before anyone.”⁹ Humility does *not* mean seeing yourself as less important than others.

This step encourages you to begin letting go of the unhealthy patterns you identified in Step Six. If some of these patterns stem from your experience of violence or abuse, you may want to seek professional help from a person trained to work with abuse survivors.

Step Eight: Made a list of all persons we had harmed and became willing to make amends to them all.

People in recovery need to acknowledge how their drinking or drug use affected others. But recovery groups remind you to make amends to yourself as well. One such amend might be to stop blaming yourself for domestic violence, sexual assault or other abuse. You are only responsible for your own behavior, not someone else’s.

This step encourages you to identify what needs changing in your relationships with others. “Making amends” does *not* mean you must reconcile with an abuser. “Amend” simply means “to change or modify for the better.”¹⁰ With an abusive relationship, this may well mean ending it. According to the A.A. literature, “If there be divorce or separation, there should be no undue haste for the couple to get together. ... Sometimes it is to the best interests of all concerned that a couple remain apart.”¹¹

Step Nine: Made direct amends to such people wherever possible, except when to do so would injure them or others.

If you have left an abusive relationship, it may be best to avoid your partner. This is true even if you believe you did something “wrong.” A.A. literature does not say you must contact everyone on your amends list. In some cases, “by the very nature of the situation, we shall never be able to make direct personal contact at all.”¹² If “making amends” to an abuser would put you or your children in danger, stay away!

Children often blame themselves for their parents’ problems. So this can be a good time to talk with your children about incidents they have witnessed. Explain that they are not responsible for your alcohol or drug use. Nor are they responsible for an abuser’s behavior toward you or them.

This step encourages you to settle with the past. “When this is done, we are really able to leave it behind us.”¹³

Step Ten: Continued to take personal inventory and when we were wrong promptly admitted it.

When doing an inventory, remember to focus on strengths as well as weaknesses. A.A. literature points out that “inventory-taking is not always done in red ink. It’s a poor day indeed when we haven’t done something right.”¹⁴

This step encourages you to maintain the progress you have made in previous steps. And give yourself credit for things well done!

Step Eleven: Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

This step encourages you to develop emotional balance. For you, this could mean prayer and meditation. It could mean keeping a journal or taking daily walks. It could mean calling a friend to help you sort out your feelings. Do whatever helps you feel centered and at peace with yourself.

Step Twelve: Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

A.A. literature says “helping others is the foundation stone of your recovery.”¹⁵ You can do this by sharing your experience, strength and hope with other people like you. When you take back your life from addiction (or abuse), you carry a powerful message!

Many recovering alcoholics and addicts believe carrying their message to others helps them stay clean and sober. Many survivors of violence find that working for social change aids their own healing process. People may call their efforts *working for change, service to others* or *carrying the message*. This step encourages you to discover what you have to offer and to pass it on!

Note: *The views expressed in this handout are the views of the author only. The author makes no claim to speak for Alcoholics Anonymous, Narcotics Anonymous or any other 12 Step group.*

¹ *Alcoholics Anonymous*, 4th Edition, Alcoholics Anonymous World Services, New York, 2001, p. 47

² *Twelve Steps and Twelve Traditions*, Alcoholics Anonymous World Services, New York, 1981, p. 27

³ *Twelve Steps and Twelve Traditions*, p. 52

⁴ *Twelve Steps and Twelve Traditions*, p. 6

⁵ *Twelve Steps and Twelve Traditions*, p. 61

⁶ *Twelve Steps and Twelve Traditions*, p. 82

⁷ *Alcoholics Anonymous*, p. 68

⁸ *Twelve Steps and Twelve Traditions*, p. 58

⁹ *Alcoholics Anonymous*, p. 83

¹⁰ *Webster’s Ninth New Collegiate Dictionary*, Merriam-Webster Inc., Springfield, MA, 1989

¹¹ *Alcoholics Anonymous*, p. 99

¹² *Twelve Steps and Twelve Traditions*, p. 83

¹³ *Twelve Steps and Twelve Traditions*, p. 89

¹⁴ *Twelve Steps and Twelve Traditions*, p. 93

¹⁵ *Alcoholics Anonymous*, p. 97

Community Support Groups

Alcoholic Anonymous (AA) is a 12-Step community group that helps members achieve and maintain recovery from alcoholism by sharing experiences with others who have suffered similar problems. Many clients who are involved with AA find another AA member who will serve as a sponsor and provide guidance and help in times of crisis when the return to substance use becomes overwhelming. This sharing and group support approach has spawned a number of similar programs, such as Narcotics Anonymous (NA) for persons addicted to substances other than or in addition to alcohol. For more information, visit their Web site at www.aa.org.

GROW. Originally inspired by Alcoholics Anonymous, GROW is an international mental health movement with a network of member-run support groups in four different countries (the United States, Australia, New Zealand and Ireland). GROW in America is fully developed in Illinois and New Jersey, and has a small core of groups in Alaska. Web site: www.growinamerica.org. Address: P.O. Box 3667, Champaign, IL 61826. Phone: 1-888-741-GROW.

16 Steps of Discovery and Empowerment. Developed by Charlotte Kasl, Ph.D., this empowerment model brings a flexible, socially conscious approach to recovery and seeks to build self-esteem while empowering people to find their own voice. Her variation on the 12 Steps encourages people to examine beliefs, addictions and dependent behavior in the context of living in a hierarchical, patriarchal culture. Dr. Kasl also suggests the “Internalized Oppression” concept vs. the term codependency. Web site: www.charlottekasl.com. Address: Many Roads One Journey, Inc., P. O. Box 1302, Lolo, Montana 59847. Phone: 406/273-6080.

White Bison, Inc. Go to this nonprofit organization’s Web site for information about the Wellbriety Movement. Wellbriety is sobriety and wellness combined. The Movement encourages American Indian and Alaska Native communities to use culturally based healing resources to find sobriety and recovery from alcohol and drugs, and other issues including domestic violence, then go beyond survival to thriving in communities. On-line information is available at the White Bison Web site: www.whitebison.org. Contact: White Bison, Inc., 701 N. 20th St., Colorado Springs, CO 80904. Phone: 719/548-1000 or 877/871-1495. Fax: 719/548-9407.

Women For Sobriety. WFS was founded with the belief that women alcoholics require a different kind of program in recovery than male alcoholics. The WFS “New Life” program is based on a Thirteen Statement Program designed to assist a woman in addressing her alcoholism and lifestyle by encouraging her emotional and spiritual growth. On-line chat groups can be accessed from their Web site: www.womenforsobriety.org. Address: Women For Sobriety, Inc., P.O. Box 618, Quakertown, PA 18951-0618. Phone: 215-536-8026.

Trust isn't always easy

People who have been traumatized may have trouble trusting others, even those who appear to have good intentions. Survivors may not trust advocates, counselors, therapists or other social service providers for a variety of reasons:

- *Negative past experiences.* People with multiple issues may have been passed from one agency to another for years without getting their needs met. Or they may have encountered providers who treated them in ways that felt confusing or disrespectful.
- *Fear of authority figures.* People with a history of trauma have often encountered authority figures who abused power, discounted them, or blamed them for their problems instead of helping them.
- *Fear of legal sanctions.* Survivors may fear prosecution if they disclose illegal behavior such as drug use, theft or commercial sex. Someone who has been incarcerated may fear going back to jail or prison. Someone with immigrant status may fear being deported.
- *Fear of being judged.* People with multiple issues may have heard repeatedly that their problems are caused by their own behavior, lack of personal responsibility, inappropriate decisions or bad character traits.
- *Fear of being discounted.* People who have been victimized by interpersonal violence often have a history of not being believed when they are telling the truth, especially if they have co-occurring issues such as a substance use disorder, mental illness or disabilities.
- *Fear of encountering stereotypes on the part of the provider.* Some survivors have encountered people who avoided or excluded them because of race, culture, disability, socioeconomic background, substance use history or mental health status.
- *Fear of losing children.* Some people fear that disclosure of parental substance abuse, mental health concerns, domestic violence or illegal activities will trigger an investigation by a child welfare agency. Survivors who have a substance use disorder, psychiatric symptoms, or physical or developmental disabilities, may fear being judged incompetent to provide adequate parenting.
- *Fear of being denied services.* Some survivors may fear being barred from a shelter or residential facility, denied public assistance or disqualified from other benefits if they disclose issues such as domestic violence, substance abuse, psychiatric issues, involvement in commercial sex or past incarceration. People who receive public assistance or live in subsidized housing may fear losing benefits or being evicted if they disclose that they are living with a partner.
- *Fear of losing autonomous decision-making power.* Providers who think they know an individual's needs better than she or he does may try to impose their own solutions and values.
- *Fear of reprisals.* People victimized by interpersonal violence may fear retaliation from the perpetrator if they report sexual assault to the police, seek an order of protection against a violent partner, or report any kind of abusive behavior directed toward them in an institutional setting.
- *Fear of being scapegoated.* Some individuals may fear being accused of things they didn't do. For example, someone who discloses a history of substance abuse or incarceration may be the prime suspect if something turns up missing from a shelter or residential facility.

Gaining trust

Despite valid reasons for not trusting others, people with a history of trauma need someone they trust enough to honestly tell as much of their story as they choose to share when they are ready. Here are some ways to demonstrate your trustworthiness and begin the process of gaining trust:

- Be willing to earn trust. Try not to be hurt or offended if a traumatized person who has been battered or sexually assaulted is angry or doesn't trust you right away. Allow people you serve to take as much time as they need to begin to trust you. Understand that this lack of trust has more to do with their life experience and your role than it does about you personally.
- Recognize all people need to earn trust and advocates, counselors and authority figures are no exception. Trust isn't automatic just because someone wants to help or is in a position of authority.
- Encourage individuals to participate in developing safety, service and/or treatment plans. This can help give them a sense of control.
- Explain what you are doing, and why, up front. No surprises. If people we serve suspect that information is being withheld from them or that they are being manipulated in any way, trust often evaporates.
- Understand that confidentiality is paramount in gaining trust, as well as an ethical imperative.
- Explain the limits of your confidentiality at the beginning of the intake process, before anyone begins talking. This may impact which issues an individual feels safe sharing with you.
- Walk the talk. If we have a different set of standards for ourselves than we have for the people we serve, we convey the message we feel superior to them.
- Believe people who tell you about traumatic incidents. Do this, even if someone seems confused or out of touch with reality, or says something you perceive as inaccurate. Try asking yourself, "What might be happening to make this seem true for this individual?" Consider how certain behaviors and beliefs make sense or could be a reasonable response to multi-abuse trauma. Don't ask, "Why are they acting this way?" Ask, "What happened to them to trigger this response? How can I help them find safer ways of coping that cause less grief?"
- Be willing to acknowledge when you don't have all the answers, and be willing to help the people you serve get the information they need.

Criticism: Constructive or Abusive?

We've all been told that a hallmark of maturity is the ability to accept and profit from constructive criticism. Unfortunately, what some people call "constructive criticism" isn't constructive at all. Sometimes criticism can be a form of abuse. So what's the difference? Here are some ways to distinguish constructive criticism from the abusive variety:

Constructive Criticism	Abusive Criticism
Stems from good motives: The motive is to help you resolve a problem, improve your work or be more successful.	Stems from bad motives: The motive is to make you feel inferior, or to look good at your expense.
Addresses the problem. The criticism focuses on your behavior or your work, rather than on you as an individual.	Attacks you personally. Examples of personal attacks include name-calling, ridicule or assaults on your character.
Respects your dignity. The person shows respect by discussing concerns privately.	Humiliates you. The individual dresses you down in front of an audience.
Notices strengths. The other person notices your efforts, and frequently offers praise for things you've done well.	Is unbalanced. The critical person hardly ever notices what you do right, and never seems to be satisfied with your efforts.
Happens occasionally. For example, the criticism takes place during performance reviews, or when you've asked for advice.	Is too frequent. The other person always finds something wrong with you or your efforts, and the criticism is relentless.
Is fair. The individual criticizes things you can reasonably change, such as tardiness or things over which you have control.	Is unfair. You are criticized for things beyond your control, such as your age or the social class you were born into.
Is calmly stated. The other person talks to you in a normal tone of voice, and treats you like an adult.	Feels threatening. The individual yells at you, stands over you, or makes threats, and talks down to you as if you were a child.
Is well timed. The person asks if this is a good time to talk.	Is demanding. The person insists on interrupting you when you are busy.
Is specific. The criticism focuses on one issue or concern at a time, and offers specific solutions.	Is vague. The individual throws in "everything but the kitchen sink" and doesn't offer any solutions to problems.
Is two-way. The individual is able to accept constructive criticism from you.	Is all one-way. The abusive individual wants to "dish it out but can't take it."

Legitimate vs. Abusive Uses of Authority

From the time we're little children, we're told to respect authority. Some people think that means we shouldn't question authority. However, if we don't question what authority means and how it should be used, how do we know when someone is abusing their power? Even legitimate authority can be twisted and distorted by abusive people to justify violence and other abuse.

And many of us are authority figures ourselves. We may be parents, teachers or supervisors. Or we may be considered experts on a particular subject. If we don't question what authority means, as well as how it should be used, what kind of parent, teacher or supervisor will we be? While authority is neither good nor bad in and of itself, how we use it matters.

What does authority mean?

There are legitimate ways to become authority figures:

- We have become an expert on a particular subject, so people listen to our views on that subject and can learn from us. Example: Teachers.
- We are entrusted with the care of others who have less power than we do, or who are unable to survive on their own. Example: Parents.
- We have been chosen by others to represent their interests. Example: Elected officials.
- We have a job that requires us to preserve order and protect public safety. Example: Police officers or military personnel.
- We have been hired to oversee and coordinate the work of others. Example: Workplace supervisors.
- We have received specialized training that allows us to help other people. Example: Doctors, advocates or counselors.

Legitimate uses of authority

People use power and authority in a legitimate way when they:

- Operate in accordance with accepted ethical standards for the position they hold.
- Are willing to accept responsibility and accountability for their behavior and decisions.

- Respect the inherent worth and dignity of others, including those in a relationship with us who have less power.
- Communicate expectations in a way that is clear, consistent and easily understood.
- Understand that trust and loyalty must be earned, even by people in positions of authority.
- Seek input from people who will be affected by decisions.

Illegitimate uses of authority

Authority is a privilege, not a right. People abuse their power and authority when they:

- Treat other people as if they have less value as human beings.
- Disregard the rights of others, including people with whom they have authority.
- Treat others in ways that show disrespect – for example, yelling or using profanity or name-calling.
- Overstep the boundaries of their authority – for example, a workplace supervisor who tries to pry into your personal affairs.
- Use humiliation, violence or intimidation to establish control.
- Take advantage of power imbalances to exploit others – for example, engaging in sexual harassment.

Our rights with authority figures

When dealing with someone who is in a position of authority, we have the right to:

- Be treated with dignity and respect, no matter who we are and no matter who the other person is.
- Ask questions about anything we don't understand.
- Get respect for our personal boundaries.
- Go up the chain of command or use grievance procedures to report abuses of authority.

Skit: Mary Has All Kinds of Troubles

Advocate: Why is this woman wearing sunglasses?

Substance Abuse Counselor: Why is she wearing long sleeves in the middle of summer?

All Helping Professionals (in unison): Hmmmmmmmmm.

Advocate: Maybe she has a black eye ... and bruises on her arms. I wonder if she's being battered.

Substance Abuse Counselor: Maybe she's wearing sunglasses to hide her pupils. And long sleeves to hide needle tracks on her arms. I'll bet she's an IV drug user.

Social Worker: Maybe she's wearing everything she owns so she doesn't have to carry it around with her. She could be homeless.

Mental Health Professional: She could be trying to attract attention to herself by dressing in an unusual manner. Attention seeking behavior is a classic symptom of borderline personality disorder.

Mary: To tell you the truth, I'm not really sure why I'm here.

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: Sounds like denial to me. Drug addicts are chock full of denial, you know.

Advocate: Sounds like she lacks awareness of abuse issues. I think she needs some domestic violence education.

Social Worker: Sounds like she lacks awareness of the community resources that are available to her. We need to talk with her about housing options.

Mental Health Professional: She sounds defensive. You know how touchy borderlines can be.

Mary: [Scratches herself.]

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: I think she's got coke bugs. She's in withdrawal.

Advocate: Oh no! I hope it's not head lice or scabies again. We had that at the shelter last week.

Social Worker: She could just need to take a shower and wash her hair. A homeless person might not have access to facilities where she can do this.

Mental Health Professional: She's going to be asking for some kind of medication. These borderlines are in our office every five minutes wanting something.

Mary: I'm afraid to go anywhere. I know I'm being watched. I've been seeing the same car everywhere.

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: Could be drug-induced paranoia. She must owe money to her dealer. Or maybe she has a warrant out for her arrest.

Social Worker: Maybe she's afraid of getting arrested for vagrancy.

Advocate: I think she's being stalked. We need to help her get an order of protection.

Mental Health Professional: But you know, borderlines love a good crisis. It helps them feel more alive.

Mary: My partner won't let me go to group sessions.

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: She's co-dependent, for sure.

Advocate: This is classic batterer behavior. We mustn't blame the victim.

Mental Health Professional: Borderlines always have to be in a relationship, even if it's abusive.

Social Worker: She might not like filling out the forms. They always ask for an address.

Mary: Okay, I know I need some kind of help. My life is one crisis after another.

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: You have a substance use disorder. You need treatment, and some 12 Step meetings.

Advocate: You are the victim of a crime. You need justice. And some education about the dynamics of abuse.

Social Worker: You lack adequate housing. You need some referrals.

Mental Health Professional: You have a mental illness known as borderline personality disorder. You need therapy. And perhaps some medication.

Mary: Since I seem to have all these problems, where on earth do I start?

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance abuse counselor: Your priority must be sobriety.

Advocate: Our priority is your safety.

Substance abuse counselor: You must accept your powerlessness.

Advocate: You need to be empowered.

Substance abuse counselor: You need to look for your part in your problems.

Advocate: You are not responsible for what happened. The perpetrator must be held accountable.

Substance abuse counselor: You need to change yourself.

Advocate: We need to change society.

Mary: You people are driving me crazy. I'm out of here!

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: She hasn't hit bottom yet. Relapse is part of the recovery process for people with substance use disorders.

Advocate: It takes a battered woman an average of seven tries before she gets out of an abusive relationship.

Social Worker: She'll be back when the weather starts getting cold.

Mental Health Professional: She'll be back when she has another crisis. Got a stop watch?

Substance Abuse Counselor: She'll be back.

Advocate: Yes, she'll be back.

Social Worker: Uh huh. She'll be back.

All Helping Professionals (in unison): She'll be ba-a-a-ck ...

DISCUSSION QUESTIONS

When the skit is finished, here are some questions to consider:

Can anyone relate to what you just saw?

What stood out for you the most?

What other labels might someone be burdened with?

What feelings did this bring up?

How can providers make sure that people are not revictimized when they seek help?

What does respectful advocacy or treatment look like?

How should Jane have been treated?

What steps can be taken to ensure that people's needs are met?

Skit adapted from model developed by King County Coalition Against Domestic Violence Interdisciplinary Training Planning Committee, 2000.

Instructions for Skit: Mary Has All Kinds of Troubles

This skit can be used in a variety of settings: to cross-train advocates and other providers; to generate discussion in a support group meeting; or to educate the public about the fragmented social services system often encountered by people who seek help for both trauma and co-occurring issues.

Note: You will need to do some advance planning for this group. For each role, you may want a yellow highlighting marker to highlight that actor's part in their copy of the script to make it easier to follow. (For example, you will highlight the "substance abuse counselor's" part in the copy of the script that you give to the person playing the role of the "substance abuse counselor," the social worker's part in the copy of the script you give to the "social worker," etc.)

CAST: Mary (an individual seeking help from the social service system), 4 Helping Professionals (Advocate, Substance Abuse Counselor, Social Worker and Mental Health Professional) and 1-4 Volunteers to tape labels on the Mary as they are mentioned by the Helping Professionals. The facilitator or a group member can moderate a discussion following the skit.

PROPS: 4 chairs up front for Helping Professionals. Sunglasses for Mary to wear. Masking tape and labels for Volunteer to tape to Mary. Make labels on 8x10 sheets of paper. Laminate them if you want to re-use them.

LABELS NEEDED: Battering Victim, IV Drug User, Homeless, Borderline, Denial, Needs DV Education, Needs Housing, Defensive, In Withdrawal, Head Lice and Scabies, Not Clean-Needs Shower, Wants Meds, Paranoid, Owes Money, Has Warrants, Stalking Victim, Crisis Junky, Co-dependent, Victim, Relationship Addict, Chemically Dependent, Crime Victim, Mentally Ill, Chronically Homeless, Powerless, Must Hold Batterer Accountable, To Blame for Her Part, Needs to Change, Hasn't Hit Bottom Yet, Get Sober, Get Safe, Get Well, You'll Never Change, You'll Be Back.

AUDIOVISUAL NEEDS: If the group is large or group participants' voices are soft, you may want to use a cordless or hand held microphone for Mary and also for the Helping Professionals.

SCENE: "Mary" puts on a pair of sunglasses and a large, long-sleeved shirt and stands in front of a row of 4 "Helping Professionals," seated in chairs. While the "Helping Professionals" are speaking, "Volunteer" tapes labels on the Mary to match the labeling language. Advise the Volunteer not to worry if labels get out of sequence.

To label or not to label?

Labels: Are they oppressive? A necessary evil? Or empowering?

Few things are more controversial than the use of labels. Some helping professionals are opposed to the use of any kind of label for any reason, while others consider labels a necessary evil. Still others consider labels to be a valid therapeutic tool and encourage individuals who seek their services to adopt them. Individuals so labeled can have a range of reactions as well. Some find labels of any kind to be oppressive while others consider certain labels to be empowering or liberating.

Here are some of the drawbacks of labels:

- Perhaps the biggest negative consequence is stigma. People with certain labels may find it more difficult to obtain employment, housing or social acceptance.
- A label can lead to stereotypes. The person with the label often becomes “Other” in the eyes of those applying the label. People may start to underestimate the individual’s capabilities or intelligence.
- Once a person acquires a label, there is often a tendency for others to view everything the person does through the prism of that label. Everything the person does becomes pathologized. Duran (2006) refers to a DSM-IV diagnosis as a “naming ceremony” in the negative sense. One survivor of multi-abuse trauma shares:

Once you stick a label on me, it’s like the usual rules of human interaction don’t apply. Instead of the give and take expected of adult relationships, you can set yourself up as the standard and insist that I meet it, rather than meeting me halfway. You can lecture me to consider your feelings, but you don’t need to consider mine because my feelings are probably inappropriate anyway. The same behavior gets described in a completely different way depending on whether you do it or I do it. For example, if you don’t agree with me on some issue, it’s a case of honest disagreement. If I disagree with you, I’m “defiant” or “oppositional.” I’m not expected to meet you halfway, I’m expected to twist myself into a pretzel trying to be you.”

- Others may accuse the person with the label of using a “fad” diagnosis to avoid accepting personal responsibility for their behavior, or as a shortcut to privileges or entitlements, or to get attention.
- Some argue that labeling promotes the formation of a negative self-identity, one that overemphasizes limitations and ignores strengths (Evans & Sullivan, 1995).
- Labeling may encourage individuals to think of themselves (and encourage others to think of them) as being only their disorder or their disease, and this may increase their exposure to the negative effects of the stigma still associated with these labels (Evans & Sullivan, 1995).

However, some believe that labels can be helpful under certain circumstances:

- A label can help an individual get needed services or accommodations. For example, insurance companies usually require a DSM-IV diagnosis before providing reimbursement for therapy or counseling services. People with disabilities must inform employers of their need for accommodations in order to invoke the Americans With Disabilities Act.

- In some cases, a label can actually serve to reduce stigma – for example, viewing alcoholism as a disease rather than as a moral failing. Evans and Sullivan (1995) argue that labeling is a universal human activity and will occur no matter what anyone wants. They point out that individuals who seek our services have already been labeled by others, in one way or another, as “bad,” “shameful,” or “weak.” These individuals may well feel that a diagnostic label is preferable to the labels they’ve already been getting, such as “lazy” or “stupid.” A survivor shares:

I’ve spent a lifetime collecting labels. When I was a child, the labels were mostly screamed at me: Stupid! Stubborn! Lazy! When I married an abusive man, he labeled me a “bitch,” “whore” and “slut.” When I began using alcohol and drugs to blunt the pain, the labels changed to “lush” and “druggie.” When I was arrested for disorderly conduct following a series of domestic violence incidents, I acquired another label: “offender.” Believe me, being told I have “the disease of alcoholism” beats the heck out of getting called “lush,” “slut,” “criminal” and so forth.

- Knowledge is power: A diagnostic label can help some survivors make sense of their experiences. For example, labeling a person’s experience as “multi-abuse trauma” can help the individual see certain behavior as a coping mechanism rather than as an indication of defective character. Judith Herman, author of *Trauma and Recovery* points out that traumatized people are often relieved simply to learn the true name of their condition. This gives them a language for their experience, and allows them to begin the process of mastery. Once a problem has a name, one can develop a plan to address it.
- A label can help clarify thinking and move people out of denial – either individually or as a society. Consider, for example, how societal reactions begin to change when people stop calling certain situations “a lovers’ quarrel” or “a date gone wrong” and start labeling them “battering,” “sexual assault,” and “domestic violence.”

So how does one resolve the issue of labels?

- Evaluate what function the label serves. Does the person affected find it helpful or not?
- Distinguish between labeling a person and naming a problem. Naming a problem, issue or experience can be empowering and liberating. Labeling a person often oppresses and disempowers.
- Evans and Sullivan (1995) suggest that when stigma and stereotyping are attached to certain labels with a valid therapeutic purpose, the task is either to change the negative connotations of these labels or to adopt labels with a more positive but still realistic tone.

Sources

Duran, E. (2006). *Healing the Soul Wound: Counseling with American Indians and Other Native Peoples*. New York: Teachers College Press.

Evans, K. & Sullivan, J.M. (1995). *Treating Addicted Survivors of Trauma*. New York: The Guilford Press.

Herman, J.L. (1997). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror*. New York: Basic Books.

Where Can I Get Help?

What community resources are used/needed for yourself or your children?

Social Security card, birth certificate, other I.D.

Agency _____ Phone: _____

Address: _____

Advocacy/counseling for domestic violence

Agency _____ Phone: _____

Address: _____

Advocacy/counseling for sexual assault

Agency _____ Phone: _____

Address: _____

Advocacy/counseling for past sexual abuse issues

Agency _____ Phone: _____

Address: _____

Housing/rental assistance

Agency _____ Phone: _____

Address: _____

Utilities

Agency _____ Phone: _____

Address: _____

Furnishings for home

Agency _____ Phone: _____

Address: _____

Phone/phone card

Agency _____ Phone: _____

Address: _____

Food/food stamps

Agency _____ Phone: _____

Address: _____

Grooming supplies

Agency _____ Phone: _____

Address: _____

Clothing

Agency _____ Phone: _____

Address: _____

Transportation/bus pass

Agency _____ Phone: _____

Address: _____

Medical/dental care

Agency _____ Phone: _____

Address: _____

Prescriptions/medication

Agency _____ Phone: _____

Address: _____

Mental health care

Agency _____ Phone: _____

Address: _____

-

Substance abuse treatment

Agency _____ Phone: _____

Address: _____

Community support group referral

Agency _____ Phone: _____

Address: _____

Counseling for children/significant others

Agency _____ Phone: _____

Address: _____

Support for disability issues

Agency _____ Phone: _____

Address: _____

Pregnancy/Sexually Transmitted Infections Screening/Testing/Services

Agency _____ Phone: _____

Address: _____

Employment assistance

Agency _____ Phone: _____

Address: _____

Child care

Agency _____ Phone: _____

Address: _____

Education/training

Agency _____ Phone: _____

Address: _____

Legal assistance

Agency _____ Phone: _____

Address: _____

Spiritual needs (including rides to church, etc.)

Agency _____ Phone: _____

Address: _____

Other: _____

Agency _____ Phone: _____

Address: _____

Other: _____

Agency _____ Phone: _____

Address: _____

We Are Our Own Best Advocates: Developing Our Own Resources

Advocates and other helping professionals are aware of many community resources that may prove helpful. Many, themselves, have had to rely on such support in the past. One evening the women at New Beginnings Wednesday Night Support Group realized they were experts on the systems they were using. Looking through a resource list provided by an advocate, a group member said, “That’s out of date. You need to go here now.” Another looking at the list said, “Oh, I would not go there, I would try this first.”

The women began exchanging tips and making a list of “personal referrals.” The group decided to develop their own resource book and began by making a list of legal resources. One member of the group asked for paper and pen. Another asked for a binder. Over time the binder grew and more meaningful resources were listed under different headings: Health Care, Recovery, Children’s Services, Public Transportation, Affordable Mechanics, Counselors, Job Opportunities, Housing, Groceries, Law Enforcement, you name it.

The women not only listed the resources. They wrote what kind of response you could expect, who could help you if things got snagged, where to turn if a helper turned into a hindrance, tips to try if you met a roadblock, options, alternatives, who could be trusted, who and what could cause problems. They wrote it all in their own words. The book got bigger and bigger as more and more group members shared options. They said, “We are our own advocates now. And who better than us? We are out there every day and this is life or death for us.”

One day the women decided they wanted to give their book a name. They narrowed their choices down to three names they liked and split the book into three sections, each reflecting an area of concern. The women decorated the cover of the book with artistic drawings, sparkles and seals and continued to add, edit and change referrals as needed. Many a New Beginnings Wednesday Night support group meeting began and ended with “The Book.”

Today you and the other people in this group are navigating helping systems. You are experts on your own lives and your own experience. Who knows more about what you are facing than each of you? You can share your experience, strength and hope with each other and with those to come, by creating your own book, one resource at a time. Begin today by sharing one resource that has worked well for you or by asking for a referral from someone in this group who may know what it’s really like to access the help you need. Tell each other what you are doing right and who can help when more options are needed. Remember, you are your own best advocates.

Safety Plan

A safety plan is unique for each individual and may need to be revised as your situation changes. A safety plan is a tool. Below are suggestions others have found helpful. You are the best expert on your own situation. Some suggestions here may be useful for you while others may not meet your needs. Feel free to add your own ideas. Take what you like and leave the rest!

The following steps will help you to prepare in advance for the possibility of future violence and will help keep you safer. Although you are not responsible for, nor do you have control over an abuser's violence, you do have a choice about how to respond to the abuser, and how best to get yourself (and your children) to safety.

Staff will support you in the decisions that you make for your life. Your physical safety will always be a priority for us. Hopefully, one or more of the following steps will help you in safety planning.

STEP 1: Safety During a Violent Incident

- If I feel the abuser is about to be violent, I will try to move to the _____. *(Try to avoid the bathroom, garage, kitchen, places near weapons or rooms without access to the front door.)*
- If it's not safe to stay, I will _____
(Practice how to get out safely. What doors, windows, elevators or stairwells will you use?)
- I will keep my bag ready and keep it _____ in order to leave quickly.

- I will tell _____ about the violence and ask them to call the police if they hear suspicious noises coming from my home.
- I will use _____ as my code word/phrase with my children or my friends so they can call for help.
- If I leave my home, I will go to _____
(Keep a list of emergency numbers in your purse or wallet.)
- I will remember that if I call 911 and leave the phone off the hook, the domestic violence incident will be tape-recorded and an officer should respond to the scene.
- Remember, you know your abusive partner best. You know how to protect yourself and your children better than anyone else.

STEP 2: Safety When Preparing to Leave

- I will leave money and an extra set of keys with _____ so I can leave quickly.
- If I own a car I will try to make sure that I keep a set of car keys with _____ and adequate gas in the car.

- I will open my own bank account by _____(date) to increase my independence.
- I can also begin to _____ as a way of increasing my safety and independence.
- I will memorize the 24-hour crisis line of the agency closest to me. That number is _____. I will keep the number in my wallet along with a quarter (if possible).
- I will check with _____ and _____ to see if I could stay with them in an emergency (*It is best if the abuser does not know them or where they live.*)
- I will review and update my safety plan.

STEP 3: Safety in My Own Home

- I will find a safe place to keep this plan.
- If my abuser has recently left, I will change the locks on my doors and secure locks on my windows as soon as possible.
- I will tell school and/or child care who has permission to pick up my children.
- I will tell my neighbors if my abusive partner no longer lives with me and ask them to call 911 if he/she is seen near my home.

If there are weapons (guns, knives, etc.) in my house, I will try to remember:

- to make sure that the gun remains unloaded at all times (I will only unload the gun myself if I know how to do so safely!!!)
- to encourage my partner to get rid of the gun if it is safe for me to do so.
- to stay out of rooms where weapons are kept, especially during an explosive situation.
- to move the knives out of their usual location so that my partner will have trouble finding a knife quickly.
- that almost anything can be used as a weapon.
- that cleaning a gun or knife in front of me is a threat and may imply that my partner is capable of taking my life or hurting my children.

STEP 4: Safety With a Protective Order (or other court order)

- I will keep an emergency copy _____.
- My children's teachers and baby-sitters will have copies of the order.
- If my partner violates the order I will call the police.
- If the police are not responsive I will _____.

- I will tell _____ that I have a valid Protective Order.
- Remember that in the State of Alaska, if your partner assaults you when you have a valid Protective Order, your partner can be charged with a crime.

STEP 5: Safety on the Job and in Public

- I will inform _____ at work of my situation, if I feel safe with this person. I will ask _____ to help screen my calls at work.
- When leaving work, I will _____ to help keep myself safe.
- If problems occur while I am driving home, I will _____.
- If I ride the bus and see my abuser, I will _____.

STEP 6: Safety and My Emotional Health

- When I have to talk to my (ex) partner, I will _____ to keep myself safe and take care of myself.
- I will read _____.
- I will call _____ for support.
- I will call my local crisis line or other support system if I need immediate help. That number is _____.

- I know that community support groups are available to help me take care of myself.

STEP 7: Safety and Sobriety

- I will remember it is easier to keep safe when I am sober.
- I know that alcohol and drug use can impair my judgment and make it harder for me to choose safe options and access services.
- I will call my local DV/SA advocate or the National Domestic Violence Hotline 1-800-799-7233 or the Rape Abuse Incest National Network (RAINN) 1-800-656-4673 when I need information, referrals or support.
- I will call a sober friend, sponsor, alcohol/drug counselor or the Alcohol Drug 24 Hour Help Line for support when I feel like drinking or drugging to cope. The help line number is 1-800-562-1240.

This safety plan is adapted from New Beginnings and Providence Health System safety plans.

PERSONAL SAFETY NOTES:

Mini Safety/Sobriety/Wellness Plan

- ★ Strategize Steps to reduce risk/use/harm
- ★ Develop Options to keep safe/sober/well
- ★ Identify Trusted allies/safe sponsors/supports
- ★ Plan Means to escape abuser/drugs/harm
- ★ Discuss Referral resources
- ★ Avoid Danger/persons, places, things/isolation
- ★ Tools HALT/One day at a time/medication

Mini-Safety/Sobriety/Wellness Plan

You are not alone.

Remember that safety, sobriety and wellness plans will change as your situation does. Each day can bring new challenges as well as rewards. Know your resources and develop safety and survival strategies.

Components of Mini-Safety/Sobriety/Wellness Plan:

- Strategize:** Secure and hide money, an extra house or car key, important documents, prescription medication information, ID, receipts, pay stubs, passports, children's school and immunization records, immigration papers, social security cards, etc.
- Develop:** A code with family/friends to signal the need for help.
- Identify:** Safe neighbor to call, network of resources who can help.
- Plan:** Escape routes, places to hide and store clothing, jewelry, photos.
- Discuss:** Referral resources, local advocates, shelter, legal options, 911.
- Avoid:** Rooms where weapons or dangerous implements are present (e.g., kitchens and knives).
- Tools:** Recognize vulnerability cues such as **HALT** (be aware when you are **hungry, angry, lonely or tired**); deal with safety, sobriety and wellness issues "one day at a time" to avoid being overwhelmed; use meditation or other activities that help you stay centered.

12 Strategies for Safety, Sobriety and Wellness

Women attempting to stay safe, sober and well may develop a plan that may include but is not limited to:

- 1.) Identifying who to call for help (e.g. advocate, sponsor, counselor, peer), forming support systems, knowing about safe support groups and meetings.
- 2.) Knowing information and getting education about domestic violence, sexual assault, substance use disorders and mental health concerns.
- 3.) Removing substances and paraphernalia from the home. Removing weapons from their usual spot in the home.
- 4.) Recognizing unsafe persons, places and things.

- 5.) Understanding how to deal with legal and other problems stemming from domestic violence/sexual assault/behavioral health issues (e.g. health, children's services involvement, poor nutrition).
- 6.) Assembling paperwork to determine eligibility for assistance or to begin seeking employment, school, housing or other options.
- 7.) Knowing how domestic violence/sexual assault can be a relapse issue, as well as contribute to depression, anxiety and other mental health concerns.
- 8.) Knowing how substance use and mental health concerns can be safety issues.
- 9.) Understanding physical, emotional, cognitive, environmental and other cues indicative of risk, and having a plan to deal with it. Recognizing the role of stress and craving, and having a plan to deal with it.
- 10.) Learning how to parent, engaging in relationships, developing sober friendships.
- 11.) Knowing when and where to run in a life-threatening situation that puts your safety, sobriety or wellness at risk.
- 12.) Having a code word children will recognize to let them know it's time to call 911.

What Does Safety Mean?

To survivors of domestic violence or sexual assault, safety means freedom from violence or abuse. But what does safety mean to people facing issues in addition to violence, such as alcohol or drug addiction, mental health concerns, disabilities or social oppression? Here are some examples of what people may need, in addition to freedom from violence, in order to feel safe:

For a person in recovery from substance abuse or addiction: Having a network of people who support recovery and sobriety. Being in an environment free of constant triggers or pressure to drink alcohol or use illicit drugs.

For a person with mental health concerns: Being able to talk about one's feelings and issues, or one's own view of reality, without fear of being discounted or acquiring yet another label. If on medication, having a reliable source of affordable refills, so one doesn't have to worry about running out.

For a person with disabilities: Full accessibility to any needed services. Freedom from bullying or exploitation. Being taken seriously rather than discounted. Being seen as a full-fledged human being capable of making one's own decisions.

For a person who has experienced societal abuse or oppression: Being in an environment where diversity is respected. Freedom from being bullied, discounted or discriminated against because of perceptions about race, gender, sexual orientation or other differences. Freedom to talk about one's feelings, issues or view of reality without being stereotyped.

For a person facing intergenerational grief/historical trauma: Having one's own customs, traditions, values and beliefs respected. Freedom to practice one's own customs or hold one's own traditions, values and beliefs without pressure to conform to the dominant culture.

For a person living in poverty: A reliable source of income, either from employment or public assistance. Knowing that one can access enough resources to meet basic needs.

For a person who is homeless: A place to keep one's belongings without fear of them getting stolen. A place to sleep without fear of arrest or of being harassed. Privacy for such things as taking a shower or changing clothes.

For a person being exploited by the commercial sex industry: Being able to talk about what's going on in one's life without fear of arrest or stigma. Being able to choose where one works, or with whom to have a sexual relationship. Freedom from exploitation.

For a person who is or has been incarcerated: Freedom to come and go from one's place of residence without constant monitoring. The ability to discuss problems or challenges without fear of "getting violated" (an interesting turn of phrase that means getting sent back to jail or prison for violating probation or parole).

Children Exposed to Domestic Violence and Substance Abuse

1. Violence occurs against both women and children in the same family.
 - a. Severe and fatal cases of child abuse may occur in homes where domestic violence and/or substance abuse overlap.
 - b. Witnessing domestic violence and being exposed to substance abuse can put children at risk.
2. Many men who physically or sexually abuse or neglect children also abuse the mother.
3. Some children who witness domestic violence are affected the same way as children who are physically or sexually abused.
4. In spite of what perpetrators and non-offending parents say, children have often either directly witnessed the physical and psychological assaults or have indirectly witnessed them by overhearing the episodes or seeing the aftermath of injuries and property damage. They are often all too aware of the impact of substance abuse in their family as well.
5. Children exposed to interpersonal violence and/or substance abuse do not experience a carefree childhood and may act adult while they are children. They may be busy surviving, placating, picking up pieces, adjusting and adapting just to stay alive.

Tactics of Abuse

Domestic violence perpetrators pose the following risks to *children*. They may:

1. Harm children by coercing them into abusing their mothers or other adult caretakers.
2. Endanger children emotionally and physically by creating environments in which children witness assaults against their mothers.
3. Physically abuse children.
4. Sexually abuse children.
5. Endanger children through neglect.
6. Focus so much attention on controlling and abusing their adult partners they ignore and neglect children.
7. Prevent adult victims from caring for children resulting in neglect.

8. Endanger children by undermining the ability of providers to intervene and protect children.
9. Endanger children by exposing them to alcohol and other drugs.

Abusers also traumatize children in the process of battering their adult intimate partner. They do so by:

1. Intentionally injuring the children as a way of threatening and controlling the abused parent. (*For example, the child is thrown at the victim.*)
2. Unintentionally injuring the children during an attack on the abused parent when the child gets caught in the fray. (*For example, the infant is injured when the mother is struck while holding the infant.*)
3. Using children to coercively control the abused parent while living with or separated from the victim. The intent is to continue the abuser's control over the victim with little or no regard for the damage done to the children. (*For example, the child is asked to report who mommy talked to.*)
4. Creating an environment where children are forced to witness domestic violence and/or substance abuse and their effects.

Examples of a perpetrator's behavior that traumatizes children include:

1. Asserting that children's "bad" behavior is reason for drinking, drugging or violence directed at the adult victim by the perpetrator.
2. Threatening pets, loved objects, toys, etc.
3. Isolating children, banning friendships.
4. Interrogating children about the victim's activity.
5. Forcing the victim to always be accompanied by the children.
6. Holding the children hostage.
7. Using lengthy custody battles as a means to continue abusing the victim; demanding unlimited visitation or 24-hour access by phone; threatening to report the victim to the Office of Children's Services (OCS) for past alcohol or other drug use.

Adapted by P. Bland from Ganley, A., Schector, S. *Domestic Violence: A National Curriculum for Child Protective Services*. Family Violence Prevention Fund, 1996.

Safety Planning Interventions For Children

It's important to safety plan.

Children:

- Are at risk and need to be safe.
- Often blame themselves for both the violence and the substance abuse.
- Feel terrified and helpless; angry and sad.
- Wonder, “What can I do?” and “What should I do?”
- Need something to ease the negative impact of domestic violence and substance abuse on their lives.
- Need the power that comes from knowledge of how to keep safe.

Safety planning with children:

- Gives them skills to protect themselves.
- Helps them feel confident.
- Empowers them.
- Gives them a reality check.
- Breaks isolation.
- Helps keep them safe.

You can help develop a safety plan to protect your children.

A safety plan should include:

- How your child can escape from the house if an assault is in progress or drinking/other drug use is scaring them.
- Where to go in an emergency.
- How to call police (explain 911 – how to call and what happens when you call).
- How to call supportive family members, friends and community agencies for help.

You can help your children.

- Listen.
- Provide structure, consistency.
- Tell your children it is important for them to be safe. If you are being assaulted, they should not intervene or put themselves in harm's way.
- Reassure children that domestic violence and/or substance abuse is not their fault and that blaming themselves is a common reaction.
- If your child is called on to testify, develop a plan to support the child over issues of fear, anxiety, divided loyalties, painful memories.
- Call your local domestic violence/sexual assault victim service program and substance abuse treatment program to get information about services for children.
- Practice the safety plan with your children.
- Ensure at least one adult provides unconditional positive regard.
- Let your children know it is OK to talk about family violence and/or substance abuse.
- Provide positive messages as well as safety planning. (*For example: "Violence is not your fault. Neither is drinking or drug use."*) Let children know anger doesn't need to lead to violence or substance abuse.
- If your children are drinking, drugging, suicidal, homicidal or violent towards other family members, develop a plan for their safety and the safety of others. Set clear limits with children who are violent and abusive or using substances themselves. Refer them to appropriate services.
- Help kids be kids. Provide after school options, encourage them to participate in children's programs. If your community does not have one, explore forming an Alateen or Alateen program. Find out what children's resources are available at your local domestic violence/sexual assault program.

(Adapted by P. Bland from material originally provided by Candy Miller, Consultant, Alaska Family Violence Prevention Project, 1998.)

Can one person make a difference?

Many trauma survivors find that working for social change aids their own healing process. People may call their efforts *working for change*, *service to others* or *carrying the message*. Whichever words people choose, the key idea is that people often help themselves by helping others. What can you do to make a difference? Here are 10 ideas to get you started:

- 1. Take care of yourself.** Working on your own issues is the first step toward working for change. As the saying goes, we must heal ourselves before we can heal the world.
- 2. Break the silence.** Going to a support group and sharing your story can be a radical act! Our society encourages people to stay quiet about certain issues. When you say “I’ve been abused” or “I’m in recovery from addiction,” others find it easier to break *their* silence.
- 3. Contribute to your support group.** Help set up tables, chairs and literature before the meeting. Help clean up afterward. Help a new person feel welcome.
- 4. Get involved in your community.** Join an organization that works for change. Donate canned goods to a food pantry. Volunteer to tutor a child at your school.
- 5. Be assertive in your conversations.** Refuse to laugh at sexist or racist jokes. Respectfully express your opinions about issues you care about.
- 6. Contact people who make decisions.** Complain to TV stations about violent programs. Call radio stations that play music glorifying drug use. Write to advertisers who promote stereotypes or sponsor objectionable programs.
- 7. Exercise your right to vote.** Also write or call elected officials to tell them where you stand on issues that affect you.
- 8. Talk to your children.** Discuss the violence they see in TV shows, movies and video games. Help them understand what happens when people do these things in real life. Educate them about alcohol and drug abuse, dating violence and other dangers.
- 9. Be a role model.** Host a potluck or social gathering where no alcohol is served. Refuse to buy violent toys or video games for your children. And don’t hit your kids. Slapping or spanking shows them it’s okay to solve problems by hitting others.
- 10. Resolve not to “look the other way.”** Call police if you suspect someone is being abused. Report criminal activities that you observe in your neighborhood.

A final note: Start small. Begin by seeking help for yourself. Go to a support group. Share your story. Talk to your children. The longest journey begins with the first step.

Writing a Letter That Gets Attention

Writing letters to the editor, to legislators, or to TV and radio advertisers is a great way to convey your position on issues that are important to you. And recipients do pay attention. Legislators want your vote. Advertisers want your business. When elected officials or advertisers get even a few letters from different people, it begins to have an impact.

When writing to an elected official:

- You may write to any elected official, but you have more influence in your own district where you vote. If you are a constituent, say so. If you supported or voted for the legislator, say that also. (If you didn't, say nothing.)
- In the first paragraph of your letter, describe the bill you want your elected official to consider. Whenever possible, refer to a specific bill by name and number, and not just to a vague issue. Make clear what your position is, and what exactly you want your legislator to do (vote for or against the bill).
- In the next paragraph or two, explain who you are. State the issue and describe how supporting or voting against the bill will help address the issue to your satisfaction.
- Express your thoughts in your own words, and make specific references to key points in the legislation. A personal story is very effective, and is your best supporting evidence. Tell your legislator how the bill would affect you, your family, or your community.
- In the last paragraph, reiterate your position on the bill and ask the elected official to state her or his position in a reply. Thank the legislator for taking the time to read your letter, and express the hope that he or she will give this important issue due consideration.
- Finally, sign your full name and address so your legislator can respond.

Here are some general tips on how to make your letter effective and get your point across, whether you're writing to an elected official, a TV program sponsor or a letter to the editor of your local newspaper:

- Keep your letter short and to the point. Write about one issue in each letter. Remember, some recipients may read hundreds of letters each week.
- Letters should be in your own words. Petitions and letter-writing campaigns with identically worded contents are not as influential.
- Type or write legibly on your own personal stationery or letterhead. The envelope should be plain white and hand-written (don't use pre-printed labels).
- Be polite. Avoid language that insults the reader, and remember to say thank-you.

Women Talk About Substance Abuse and Violence

Ten women were interviewed about their experiences with substance abuse and violence. All 10 were survivors of some form of abuse: battering, rape or sexual assault, incest or child sexual abuse. In addition to the violence, all of them had experience with alcohol or drug abuse, either on their own part, on the part of their partner, or both.

At the time of the interviews, all of the women had left their abusive relationships, and those with chemical dependency problems were in recovery. They talked frankly about the impact of the substance abuse on their efforts to escape the violence and heal from abuse. They also discussed the ways in which their experiences with violence affected their efforts to recover from alcohol or other drug addiction.

Q: What was your experience with physical or sexual abuse?

A: I was in my abusive relationship for 16 years. I couldn't eat or sleep or go to the bathroom without permission. I was beaten. I was repeatedly raped. I had guns in my ears, guns down my throat, guns at my neck, guns at my stomach. I couldn't tell anyone the truth because he said he'd kill me. I knew he would.

A: Our third date he moved in with me. And about a week later he punched me upside the head and knocked me out of a chair. One night he dragged me out of bed cause I wouldn't give him any money and beat me up. I said no one time and that was it. He just started beating me. Just cause I said no.

A: After six weeks of dating, this man tried to strangle me.

A: I was a 17-year-old unwed mother and 2 days after I found out I was pregnant, he made me pull the car over and when I got out of the car, he hit me with his fist in the stomach.

A: He raped me. And when the kids came home from school, he bought them a pizza. We all had pizza. He could come home and rape me, order a pizza like nothing happened.

A: I was sexually abused when I was 5 years old. He fondled me and I fondled him. I knew that something was wrong. He said not to tell anybody.

A: I had incest in my life. I remember being in my mother and father's bedroom. And I remember feeling real physical harm inside. I had severe vaginal pain. I don't know how long that went on, but I do know it all happened before I was 8 years old.

Q: What were your personal experiences with alcohol or drug use?

A: When I was a little kid, we all got shots of whiskey. And I loved it. You got that warm feeling and everything was going to be okay.

A: For as far as I can remember, I've had some sort of substance in me. I started using drugs when I was 10 years old.

A: I had my own little chair in a closet and I'd go sit in there, just me and my bong.

A: We used marijuana every day. I did a lot of cocaine. When I used cocaine, all I wanted to do was that next line. I didn't care about putting the kids on the bus or getting the kids to school. I lost my children.

A: I was a blackout drinker from the age of 15. My alcoholism was sitting home sipping wine all day. I could sip the whole gallon. I thought I was crazy. Not really thinking, well, it's the alcohol.

A: One day I didn't want to drink and I had to. It was the scariest feeling. I got the shakes. I was real nervous, and I knew a drink would fix that.

Q: Did you see your substance abuse and woman abuse as being connected in any way? For example, did you drink or use drugs to help you cope with your feelings about the woman abuse?

A: Whenever he'd get really angry and the fights would start, it was easier for me to just go in the back bedroom and get stoned and try to put it all away.

A: For me, the substance abuse when I first started using was over abuse, was over a rape, and so that's how I learned to cope with any type of abuse was to get high, and it made everything okay.

A: I was darned lonely. I had no friends. I had nobody to talk to. So I started smoking more, getting high more often, with every aspect of the abuse, between the isolation, the physical abuse, the sexual abuse. This way, I didn't feel any pain. I didn't feel any guilt. I didn't feel anything. I didn't want to feel.

A: I just didn't want to be conscious of my actions or his actions.

A: All I know is, when I was being abused, all I wanted was more and more. The marijuana wasn't enough. Then I started getting into the crack. It was easier just to stay stoned and numb and not have to deal with it. The drugs were what made me forget about all the abuse and set aside the fear and the terror I had from the abuse and that was my only escape. It was a way to get away from my husband and not feel trapped.

A: I've known for 10 years that I had a serious problem with drug use but I was not willing to give it up because that was my way of coping. The drug didn't hurt as bad as reality hurt.

Q: Did your partner abuse alcohol or other drugs? If so, did you see a connection between his substance abuse and the violence?

A: The basement was off-limits to me. I was never allowed in the basement. He was a drug addict and that was where he kept most of his drugs.

A: He drank, and he used marijuana heavily. He also used other drugs. The abuse kept going. Not even just when he drank. I mean stressful times. He really hurt me, and I remember just laying, pregnant, in a ball, sobbing, as he just drank himself into oblivion.

A: The abuse escalated, especially when he was coming down from coke, or if he had a hangover from coke.

A: He was violent when he wasn't drinking, but he was more violent when he was drinking. Any little thing would set him off. He'd wake up and want more alcohol. And then the cycle would start all over. I kept thinking in my heart that if he'd only quit drinking, then life would be a lot better. I've come to the understanding that a person is going to drink or not drink. It's their choice.

A: If you sober up a perpetrator and he doesn't have treatment for his issues, then what do you have? You have a sober perpetrator. And now he's more aware.

Q: Did you find that substance abuse got in the way of your efforts to cope with the battering or heal from other forms of abuse?

A: It got in the way a lot. I left the shelter because he bought a bag of cocaine. And so, here I was back in the same abusive relationship all over again. I wanted to be strong, and even though I wanted to be out of an abusive relationship, my addictions took me back.

A: I didn't have time to heal. Because every time you drink, then there's no emotional growth. Or you just start to look at an issue like alcoholism or domestic violence. You just start to look at the sexual assault and it's too painful. You drink to numb the pain. So it never really goes away. It's never dealt with. It just gets under the rug, and it resurfaces again and again.

A: It made it certainly harder for me to cope.

A: I first went looking for help to get away from the abuse. While I was in shelter, one of the things they very strongly enforced was no alcohol or drugs. And I was having a real hard time with the no drugs. So my pipe and all my goods and stuff stayed in my car. I'd get in my car and go down a couple of blocks, sit in a Safeway parking lot and get stoned.

A: The drugs are an element of control. If they can keep you on the drugs, using or addicted to the drugs, they're in control. And it's like strings on a puppet. They just keep you under control because you want that other hit. You want that other drink.

A: And drinking kept me in the relationship longer. When you're drinking and you're in that vicious circle, the other vicious circle doesn't matter. All I cared about was getting another drink.

A: Because of my drug use, I would not accept or see the violence. My head's not clear enough, or wasn't clear enough, to see the reality of the situation.

A: For me, once I pick up the alcohol or the other substances, it's like that safety plan goes out the window.

A: It kept me isolated, so I stayed at home in my room with the curtains drawn. On top of him keeping me isolated and not allowing me to go anywhere. But I think the biggest thing it did was kept me from getting out and getting that help I needed. Now, being clean and sober, I know it's so much easier for me to tap those resources.

Q: Did you find battering or other abuse got in the way of your efforts to recover from substance abuse? Was this ever a relapse issue?

A: Every time I thought about getting into a new relationship, I just wanted to drink.

A: I think the underlying shame that I felt, and not dealing with the sexual assaults. I didn't see that at first when I got sober. The connection didn't become clear to me until I'd been in recovery for some time.

A: Not being able to go to meetings. Not being able to get out around people who were sober.

A: Going to a meeting wouldn't be anything he would tolerate because there would be other men there. Something could happen. So his controlling made it real difficult for me to do what I needed to do for myself.

A: I made it for 30 days. The minute I got out of the safe environment I was right back with the man and by midnight, using.

A: I believe I needed more than just a 12-step program.

A: You can talk about all these wonderful spiritual things, but if you don't have any food and you don't know where you're going to sleep, and you're running for your life, you don't have time for any of that stuff. You're just stuck on survival.

A: This man tried to strangle me. After that happened, then I relapsed. And I was in relapse mode off and on for a whole year after that.

A: I think when you stop denying things that have happened in your life in the beginning, all that from the incest, then you can stop the denying of things that happened a couple of years ago. Sick relationships and the drug abuse, and the self-destruction. I think from that point on, I could start to recover.

Q: Did you get any messages from others that you were to blame for battering or other abuse?

A: Yes, I got that message from family, friends and my abuser. It was always my fault.

A: He said I was ugly. He said I was a bad wife. He said I was an unfit mother.

A: Well I told you to shut up and you wouldn't shut up. Or all you had to do was make me bacon. Or I didn't hit you that hard.

A: I chose to marry a man from the other side of the tracks. Deal with it.

A: My parents and my family, they liked him. They said it was my fault he started drinking, because I was nagging him. I wasn't treating him right. That was the reason he broke my face, broke my nose, broke my jaws. I was doing something to cause him to hit me. It was my fault.

Q: Did you believe this yourself?

A: He told me it was my fault that he hurt me. And I believed him. After all, he didn't rage at anyone else, and he didn't hit anyone else but me.

A: It just whittled away. I was told regularly if you hadn't done this, then I wouldn't have done that. Over a long period of time to the point where I thought I was crazy. And I really started to believe, if

I act just right, I can keep this from happening to me.

A: Part of his abuse was brainwashing, and he was very good at it.

Q: Did you get any messages from others that you were to blame for battering, sexual assault or other abuse because of your drinking or drug use?

A: He was always saying the reason he would abuse me was because of my drug use, even though he had his drug use that was not a problem, or he would bring the drugs to me.

A: He would not admit that he was abusing me. But he was like, you did the drugs. You deserve to get your ass kicked. My mom always took his side. She was aware of my marijuana use and my cocaine use, and she'd be like, what man is going to put up with the things you do? And I got that from a lot of people. All the time it was, I deserved it because I wasn't being a good mom, I was using drugs, running around to taverns and staying up all night, and sleeping all day. Oh, yeah. Big messages.

A: I had been raped, gang raped, when I was 17 and I had been using. I didn't even realize it was rape until a woman pointed that out to me. She said any time you have sex without your consent it's a form of rape. I think that the attitude about women, if you hadn't put yourself in that situation then that wouldn't have happened to you. What did you expect?

Q: Did you believe these messages yourself?

A: Yeah, I believed it for a long time. He kept telling me I was the one who was insane, and that I was always going to be that way as long as I used the drugs. So it was my fault that I made him angry. When I'd really get into the crack I would get to the point where I'd get suicidal. And then it was him not being able to cope with my mood changes and stuff like that.

Q: When you tried to seek help for the violence, did you run into any problems? How did people respond?

A: The cops would come and they'd say, you've been together how many years? Get over it. Kiss and make up.

A: We come from a very small town, and when I got my divorce, the judge told me, we do not mention the words domestic violence in this courtroom.

A: The first time he tried to kill me, we went and saw a psychiatrist, family counseling, and I actually did kick him out of the house. The psychiatrist wanted him back in the house, told us we should be able to work it out.

A: I went to the church and told them that I was in fear for my life, and if somebody would just go with me from the church, I could get my cat and I could get my belongings. People in the congregation patted me on the head and told me, "Oh, it's okay." Denying that there was any abuse going on. It made me turn my back on my faith.

A: People tend to look the other way. It's just not something they want to see. It's denial.

Q: Were there any personal barriers that stood in the way of your getting help for the battering or sexual abuse?

A: I never thought I'd have the strength to leave. I never knew I could. I didn't have the resources that we have now. I did not know domestic violence was against the law. I had absolutely no idea.

A: I was afraid of what life would be like alone, big time. Of the mom thing. Three children. And so finances kept me there too. I thought the only thing to do was to stay and keep on doing what I was doing. You know, domestic violence is barely out in society now. Until the police told me about the battered women's shelter, I didn't know there was help, and I think I was pretty unaware of substance abuse help too. I just didn't know.

Q: What kept you from getting help for the substance abuse?

A: The feeling of isolation both being a female alcoholic, that internalized shame, and then the internalized shame I had from the domestic violence.

A: Pretty much what people would think was the biggest thing. The shame pretty much kept me from getting any kind of help that I needed. I just stayed addicted.

A: I thought alcoholics were people in the gutters, the winos pushing their shopping carts with all their belongings in it. And I figured since I had a job, a car, the whole nine yards, that I was doing pretty good.

A: I didn't think marijuana was addictive.

A: How do you get up in the morning and not smoke a joint?

A: And denial is an awesome thing. It truly is. If you don't want to see it, or you can't handle it, then it simply is not happening.

Q: When you were trying to recover, did your partner ever try to put roadblocks in your way?

A: Oh yeah. Because it was really tough for me when I first quit. It was difficult the first 30, 60 days. When I talked to him on the phone, he'd always tell me, all you've got to do is tell me babe, and I'll go get you some more. He kept telling me that that's all I needed was a couple of bong hits or a couple of rocks and I'd be just fine.

A: I got clean and sober and started working, and putting money away to get out of the relationship. And I think he saw that. He became more demanding. Attempts to be controlling escalated. His abuse of the kids escalated as I was sober. His attempts seemed more desperate.

Q: What finally led you to get help for the woman abuse?

A: This man was just physically beating me up. My middle daughter was between us a lot of times, and while she was standing between us, he would reach around her and pull my hair. I walked into her bedroom to check on her, and she was hiding underneath the bed. I realized he was affecting the kids.

A: The nice periods were shorter and shorter, and the abuse got longer and longer. Just couldn't take it anymore.

A: When I was using, I didn't have the ability to reach out for help, nor did I feel I needed it. Not using made me feel again, and when I felt again, I knew I needed help, because the pain was there. And that's when I reached out. If I would continue using, I would never have reached out.

Q: What led you to get help for the substance abuse?

A: The choice of either stop using or live on the street. At this time, I was smoking crack cocaine. Because I was so devastated by the use of it, I just wanted to be really free from it.

A: Once I walked away from that abuse [violence], I knew the next thing I had to do was do something about the substance abuse. And then, when I made up my mind that I wanted to quit the drugs also, the advocates at the shelter were right there for me, and got me into a treatment program.

Q: Do you think it's important to address both violence and substance abuse together?

A: I don't think I could deal with one issue alone. It was critical that I deal with the domestic violence, to get away from it, because it was just getting worse and worse. But I couldn't deal with the domestic violence if I was still getting all drugged up.

A: You've got to be sober, at least a little bit, to be able to even look at the domestic violence. But if you get sober, and you don't look at those issues, you're not going to stay sober, not in the long run.

A: I couldn't recover from substance abuse if I was still being physically abused, mentally abused, because I would be right back to using. So they walk hand in hand. I would not recover from one unless I address the other, and vice versa.

A: Without being clean, I can't deal with the abuse issues, and without dealing with the abuse issues, I'll just go back to using.

A: Getting off the chemicals has made it much easier for me now to deal with the other situations I need to in order to get back on my feet.

Q: What has been most helpful to you in addressing both the substance abuse and the woman abuse?

A: I'm going to a domestic violence group that also addresses chemical dependency issues. The domestic violence and drug abuse have very similar qualities.

A: You have the minimizing. The denial. All that stuff that goes on with the chemical dependency, you have with domestic violence too.

A: I get a lot of support on both issues this time around.

A: Accepting suggestions and help from other people. Being clean and sober and seeing the potentials that I have.

A: Staying clean and being able to talk about what's going on really helps.

A: It helps to see that you aren't the only one. And that someone else did make it. And someone else has made a life for themselves.

A: They try to make you feel that you're not worthless or useless.

A: Somebody wanted to show me support, listen to me, not yell at me, not scream at me, just look at some options instead of that. Through them showing love to me, I began to love myself. I didn't deserve the punishment I was giving myself for all that had happened in my life. The continuous bad relationships, continuous abusing the drugs, and shame and the guilt I felt from all that. I deserved better. It was also OK to heal from all that.

A: The longer you're clean, the more you talk about it, the easier it gets. And it feels in the beginning like it's the end of the world, but it's actually the beginning of a new life.

Q: What has been your experience with support groups? Have you been encouraged to talk about both issues? How do you handle this?

A: I have a sponsor in a 12-Step program. And she is both a survivor of domestic violence, and in recovery for 14 years.

A: I'm very determined to live a violence-drug free life, so regardless of what kind of meeting I go to, I talk about what I feel I need to talk about. Anytime I talk about my domestic violence, I'm also speaking on my chemical dependency. I go to groups and I say what I feel I need to say. The meetings I go to deal with both.

A: For domestic violence survivors, women's meetings are probably safer.

A: Where it was safe to talk about both the chemical dependency and the domestic violence.

A: Especially with other women who have both issues, those who know the abuse, all aspects of the abuse.

A: The more you tell your story, the more you talk about what you did to get clean and sober, the stronger it makes you the more you hear it. And the longer we're away from the abuser, and the more education that we get, and the more we talk to other people about it, the stronger we become and the more aware.

Q: Many women have mentioned problems they encountered when they first tried to seek help. Have you done anything personally to try and change attitudes about chemical dependency or violence against women?

A: Being a sponsor in the A.A. program. Just talking with some of the new people that are coming in.

A: Just sharing it with other people in the meetings, my experience of how I am now, compared to where I was when I first realized I needed to start doing something about the problems.

A: When I'm helping other people, it's keeping me conscious of where I'm at in my program and what I'm doing to take the steps to keep myself clean and sober.

A: Because of all the stuff that I've been through, with personal journeys, the law, and the police and the court system, I want to get involved in effecting change.

A: Working with other addicts and abused women and homeless women, that's my healing every day.

A: And put DV information everywhere. I have put it everywhere I can think of. I've got it in the schools, in the libraries, in the grocery stores, in the movie theaters, in the dentist office, in the car dealerships, in the tourist information centers. You name it, I put it there.

Q: What would you say is the best thing about being both safe and sober today?

A: I've gained more confidence in myself and learned so much more about myself. It's still lonely. It's still quiet. But it's better than being drugged up and arguing and fighting all the time. I don't have to run and hide in a closet anymore.

A: I have my youngest daughter back. She lives with me. My oldest daughter is getting married, and my middle daughter is a college student. I was blessed with talking to 3,000 teenagers this fall at the convention center. No line of cocaine, no reefer, no drugs, no man, ever brought me to the feeling of being able to talk to those children.

A: I'm able to have clear thoughts. I have a sense of reality. I'm not easily swayed. It's easier for me to pick out unsafe situations and unsafe people. By being sober, I'm more aware of what's going on around me. I don't have to be in another abusive relationship and I don't have to let people treat me like that.

A: I'm a pretty intelligent person, and I never realized that. I never realized how really intelligent I was.

A: I am my own advocate, I realized.

A: I have a lot of women friends and I've never had women friends. Never.

A: I wouldn't trade where I'm at right now. I remember that feeling. I remember the withdrawals. I remember the cocaine dreams too vividly. Nightmares. Don't want to go back. Ever.

A: I am, for the first time in my 41 years dealing with life on life's terms without somebody telling me how to do it. I can actually talk to people now without being drunk. I can actually laugh without being high. And I can actually walk out a door without being paranoid. That feels good. That feels so good. Because I want to live.

Q: What would you tell other women who are experiencing substance abuse and violence?

A: That you can get out of an abusive relationship. That you can recover. That you're not alone.

A: No relationship is better than an abusive relationship.

A: And I don't think women should feel they need to make a man happy. That's a two-way street.

A: Just taking even baby steps toward asking for help. That was the biggest and most difficult thing for me to do.

A: It's hard picking up the phone, but both problems have hotline numbers. And once you do it, it just gets easier after that. And if you don't get help, it just gets worse. A lot worse. Both issues.

A: Please reach out. Talk to a peer. Talk to somebody you can talk to.

A: I can't go back. I can't truly ever return to that state of denial. I know too much now.

A: Knowledge is power. ... Knowledge is power.

Based on interviews conducted by
Debi Sue Edmund and Patricia J. Bland
in Springfield, IL, and Seattle, WA.
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Real Tools: Responding to Multi-Abuse Trauma
Alaska Network on Domestic Violence And Sexual Assault

POWER AND CONTROL WHEELS

The original Power and Control Wheel was developed from the experience of women in Duluth, MN, who had been battered and abused by their partners. The Wheel makes the pattern, intent and impact of violence visible. It has been translated into more than 40 languages and has resonated with the experience of survivors worldwide.

The Wheel is used in many settings and can be found in manuals, books, articles, and on the walls of agencies that seek to prevent domestic violence. Besides being used in shelters to educate survivors about the dynamics of abuse, it has also been used to train other professionals and educate the public. The Duluth Model Web site (www.theduluthmodel.org) reports that the Wheel has even been seen by millions of viewers on national television shows and soap operas!

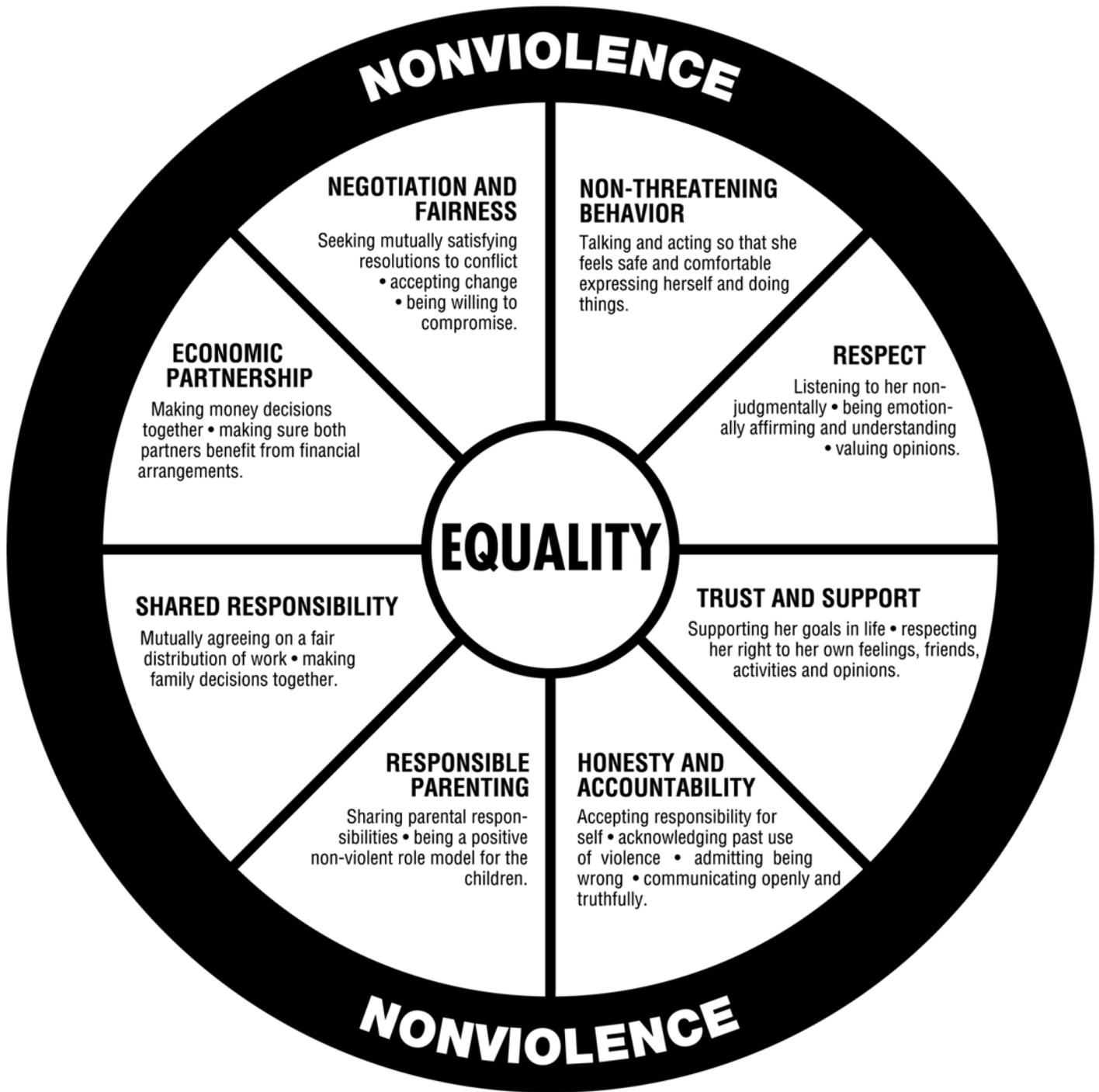
Adaptations of the Wheel have been developed by others to reflect cultural considerations and to reflect special situations such as substance abuse and mental health concerns. The Power and Control Wheel and its variations appear in *Real Tools* courtesy of the National Center on Domestic and Sexual Violence, which credits the Domestic Abuse Intervention Project in Duluth, MN, for inspiring the wheels. For more Wheels besides the ones appearing here, go to www.ncdsv.org/publications_wheel.html.

Trainers and group facilitators are free to photocopy as many of the Wheels as they wish for educational use. However, the National Center requests that the copyright notices appear on each of the handouts. The National Center also requests that the Wheels not be altered in any way.



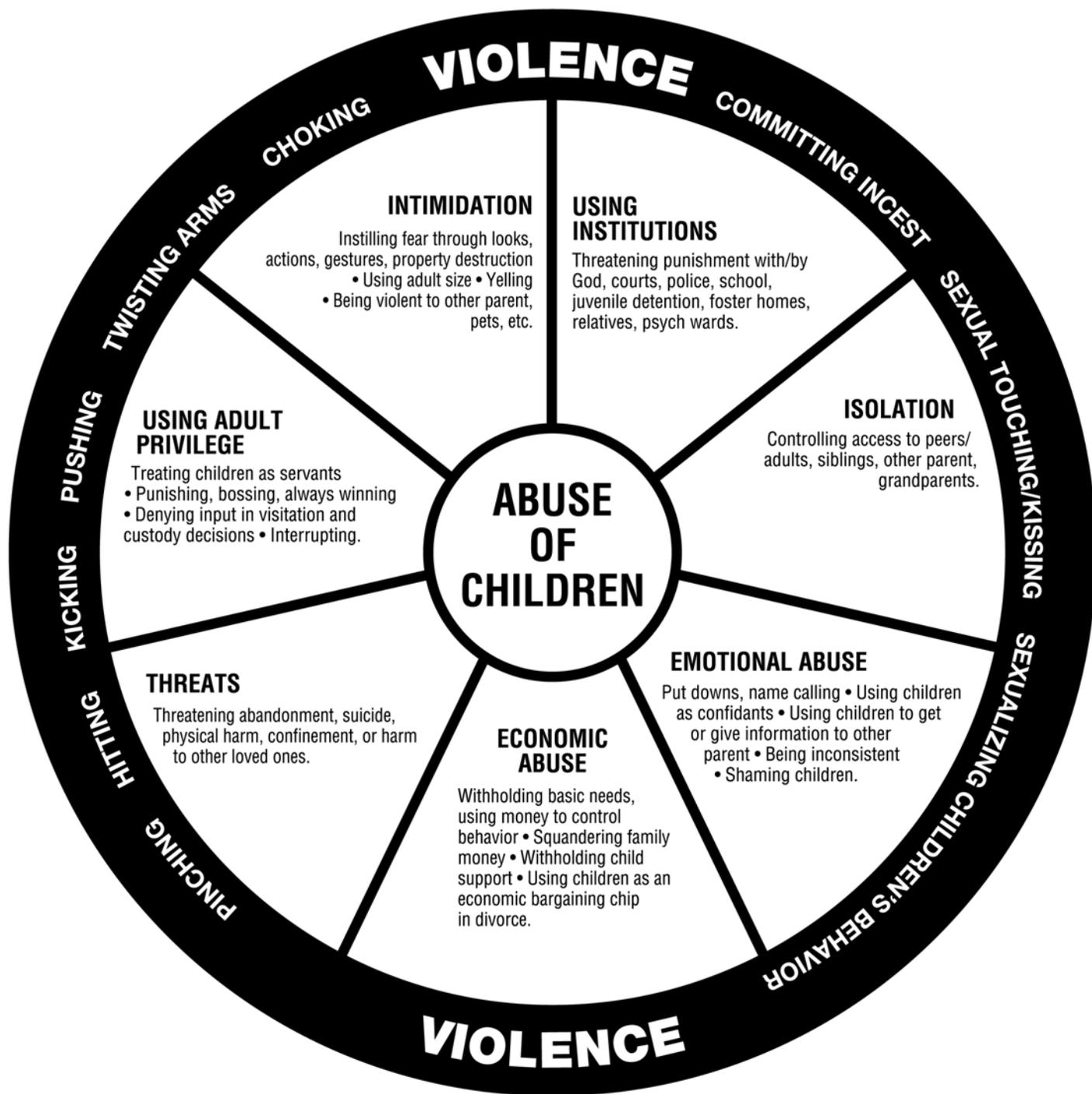
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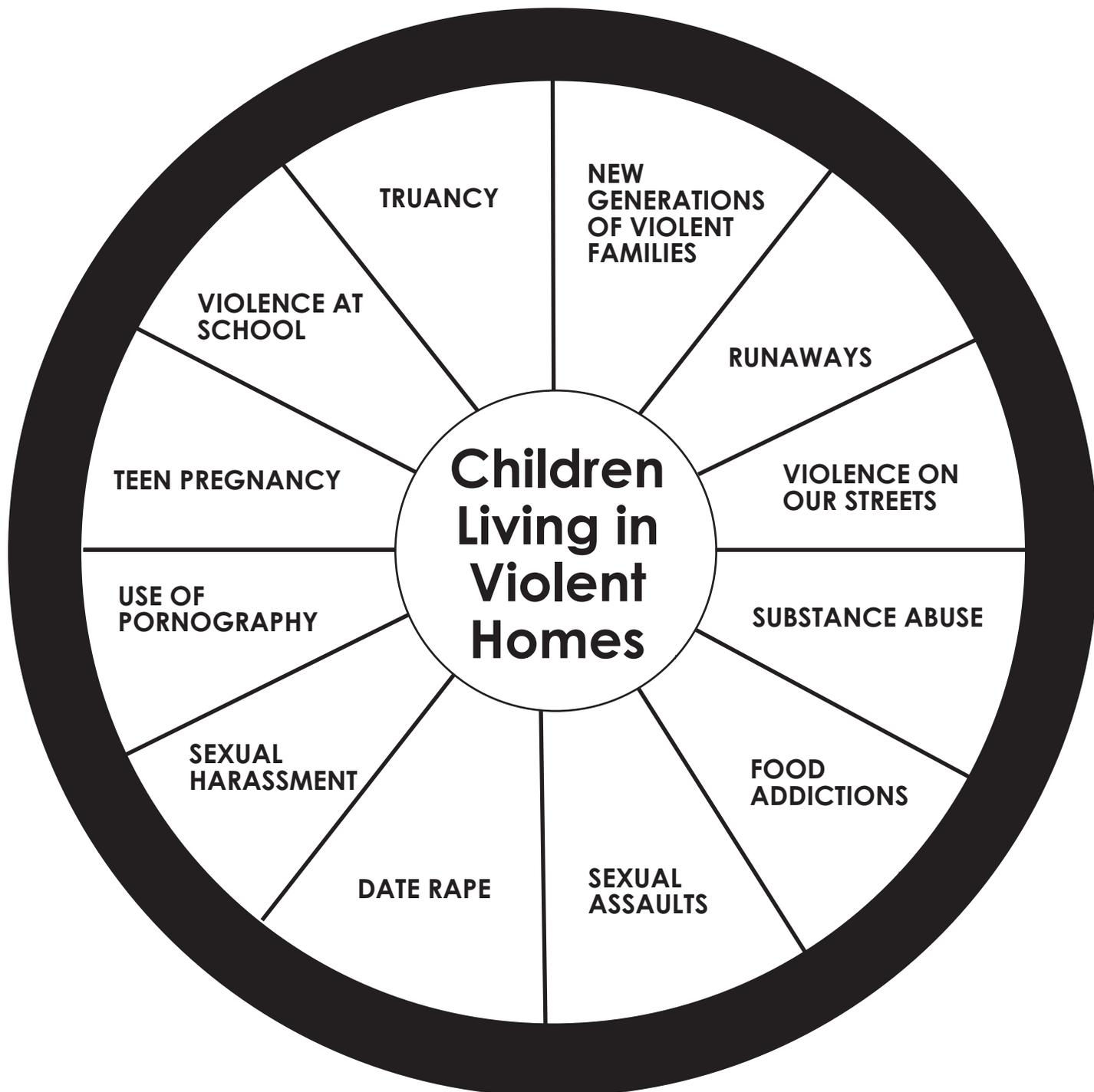
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www.duluth-model.org

CHILDREN COPING WITH FAMILY VIOLENCE



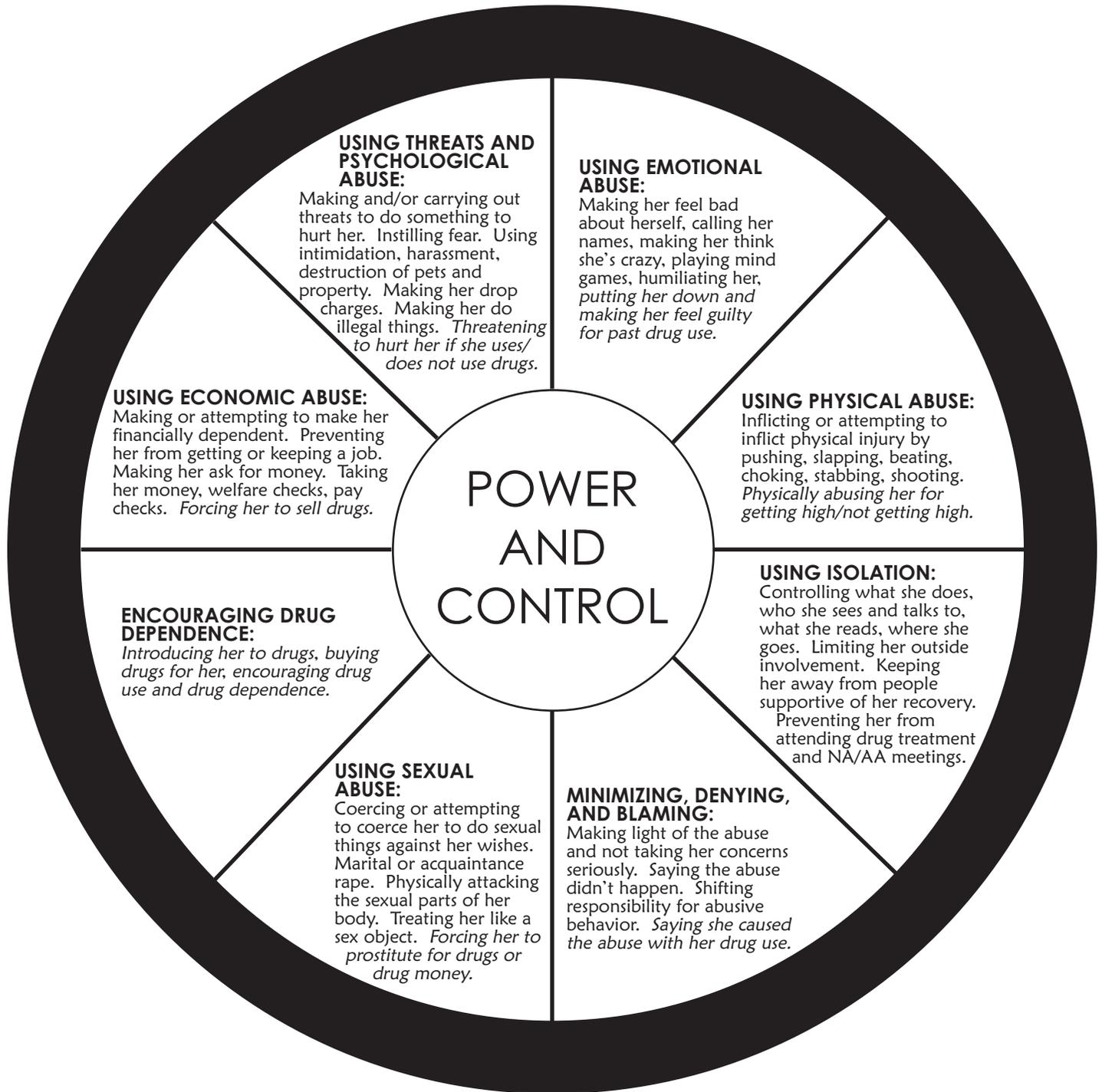
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POWER AND CONTROL MODEL FOR WOMEN'S SUBSTANCE ABUSE



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Excerpted from:
"Safety and sobriety: best practices in domestic violence and substance abuse," p. 66,
Domestic Violence/Substance Abuse
Interdisciplinary Task Force, Illinois
Department of Human Services.

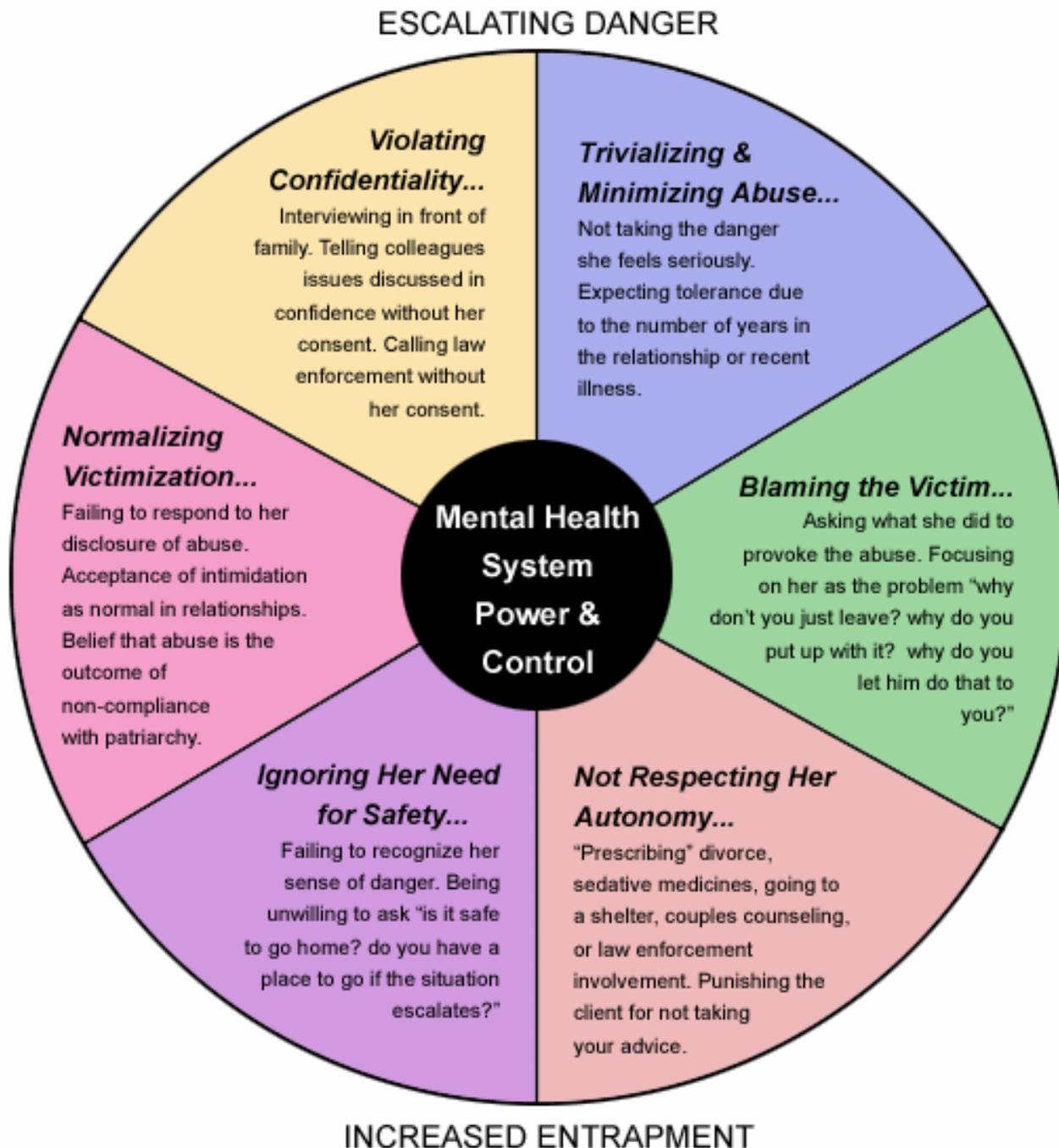
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Mental Health System Power & Control Wheel



DVP, Inc. Kenosha, WI, 1992

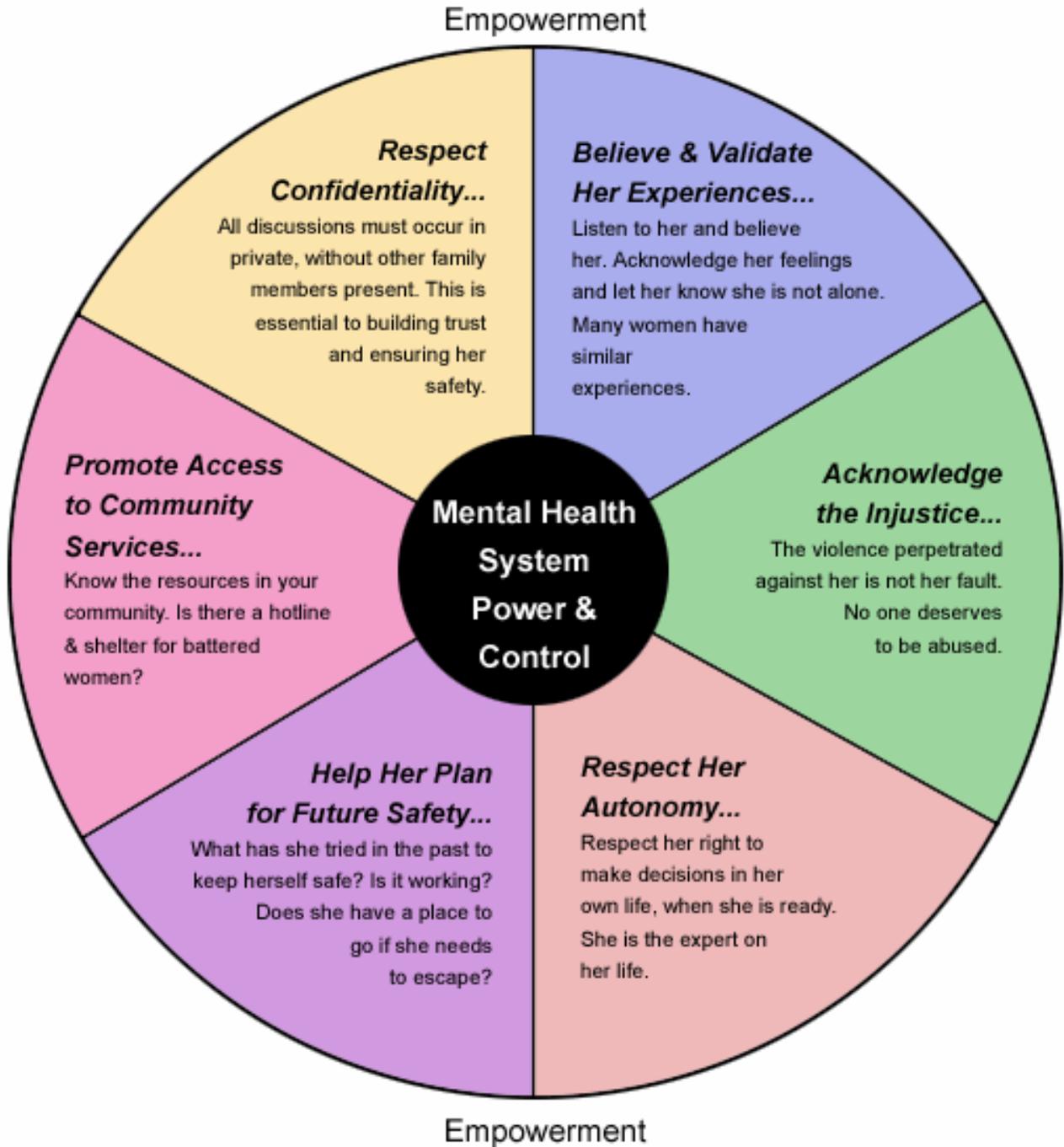
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THE ADVOCACY WHEEL



DVP, Inc. Kenosha, WI, 1992

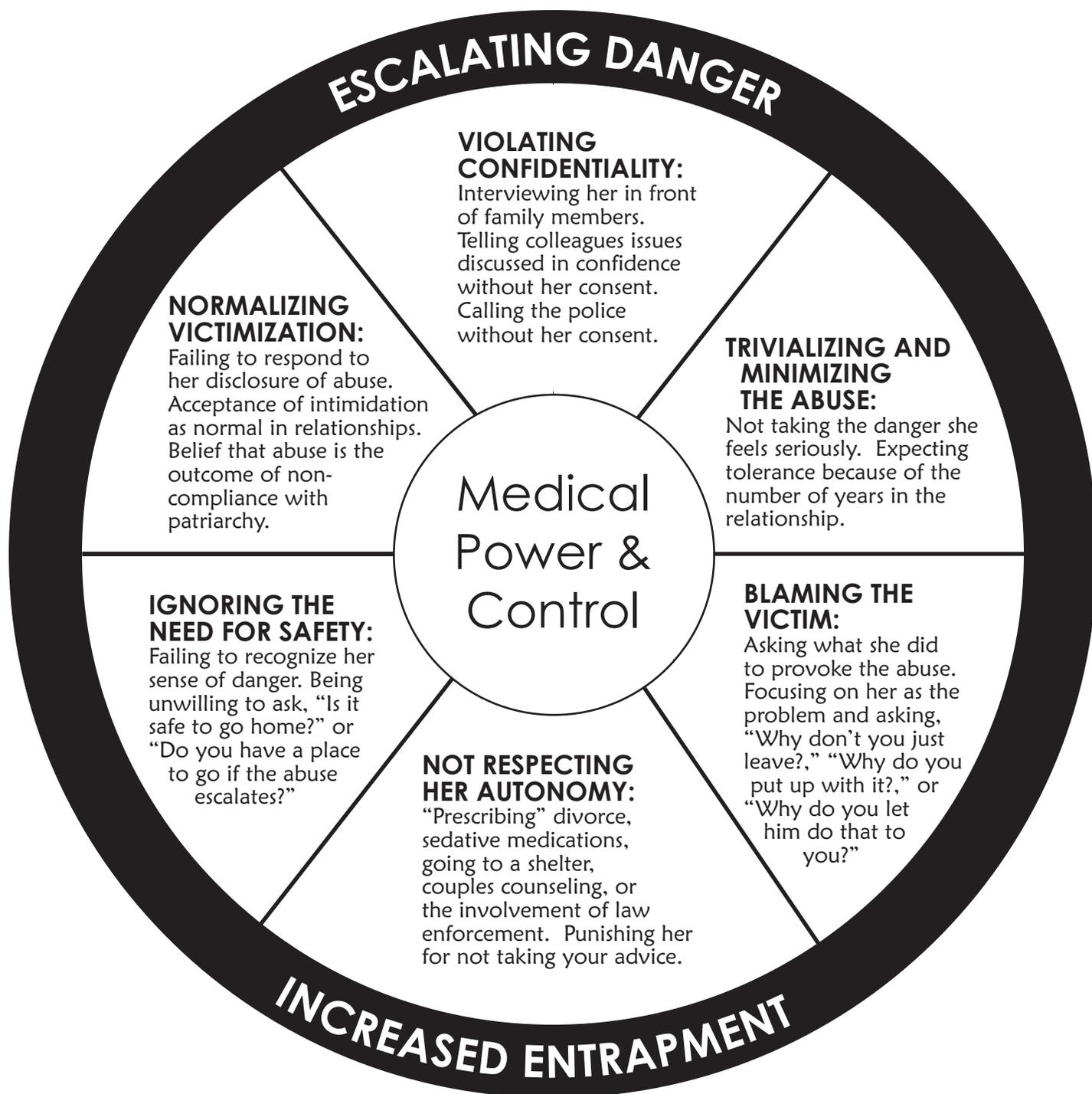
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MEDICAL POWER & CONTROL WHEEL



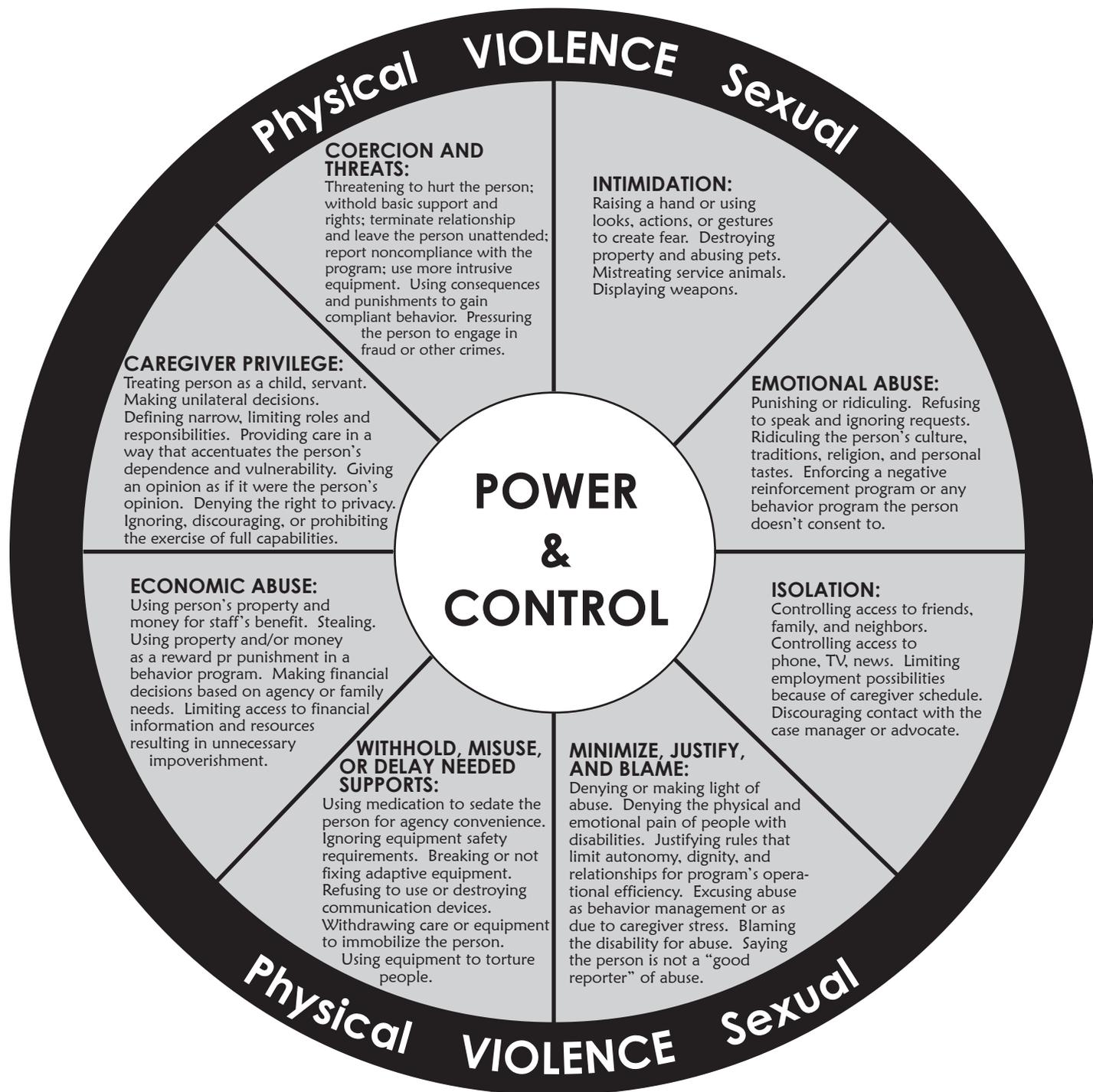
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Kenosha, WI, adapted from the original wheel
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POWER & CONTROL WHEEL: PEOPLE WITH DISABILITIES AND THEIR CAREGIVERS



Developed by:
Wisconsin Coalition Against Domestic Violence
307 S. Paterson St., Suite 2, Madison, WI 53703
608-255-0539

Based on the model by the Domestic Violence
Intervention Project, Duluth, MN.

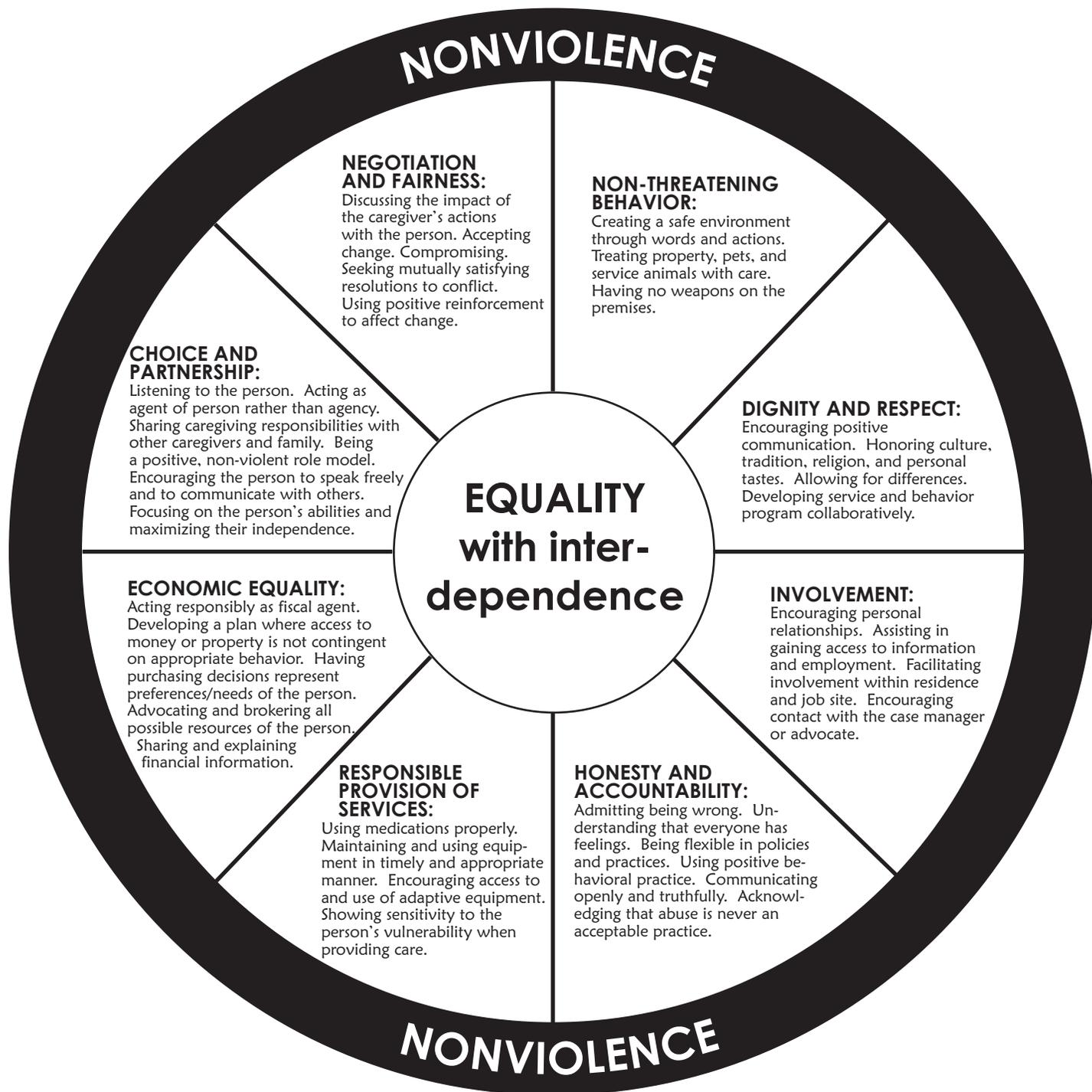
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EQUALITY WHEEL: PEOPLE WITH DISABILITIES AND THEIR CAREGIVERS



Developed by:
Wisconsin Coalition Against Domestic Violence
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608-255-0539

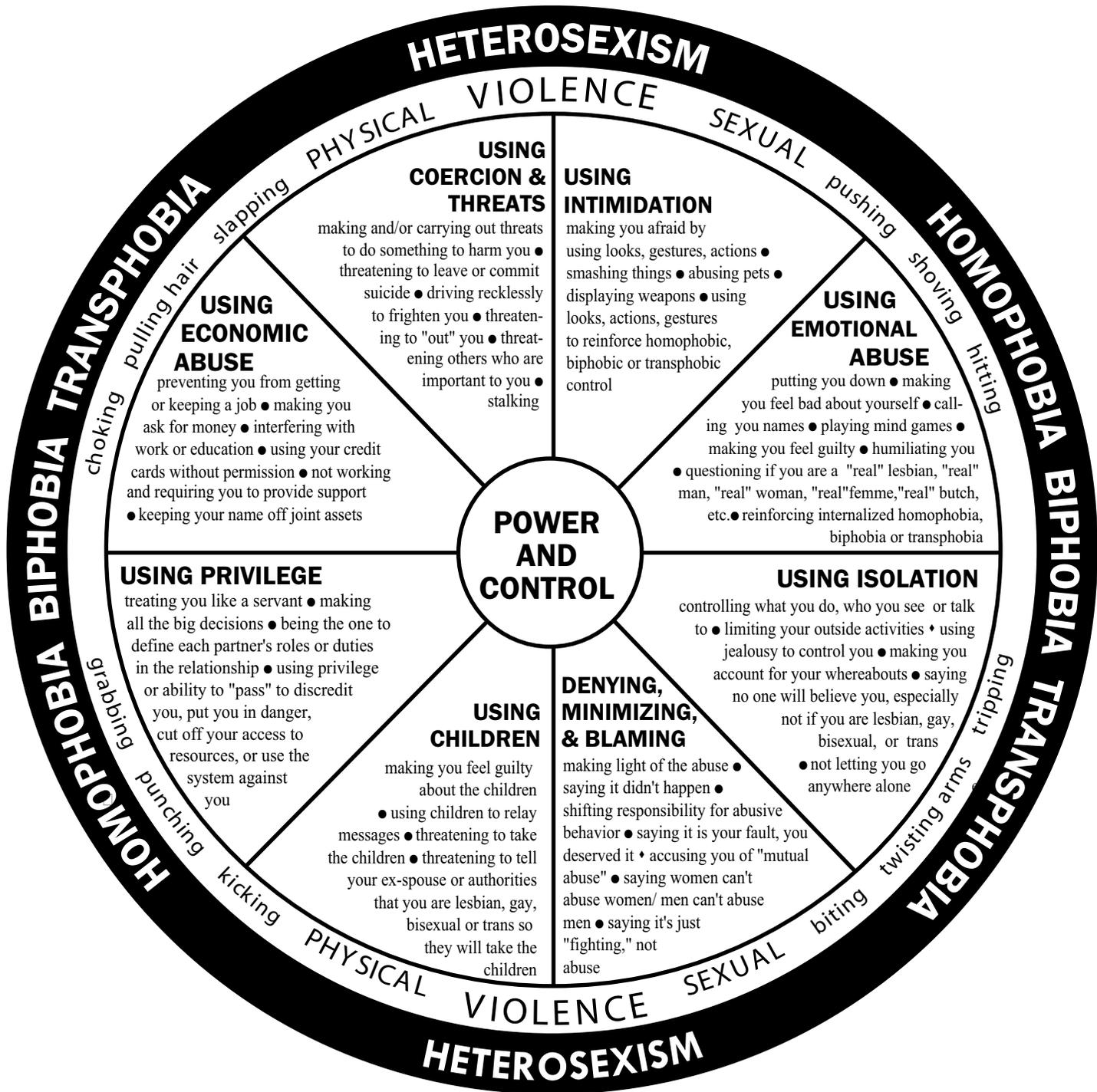
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Gay, Lesbian, Bisexual and Trans Power and Control Wheel



Developed by Roe & Jagodinsky

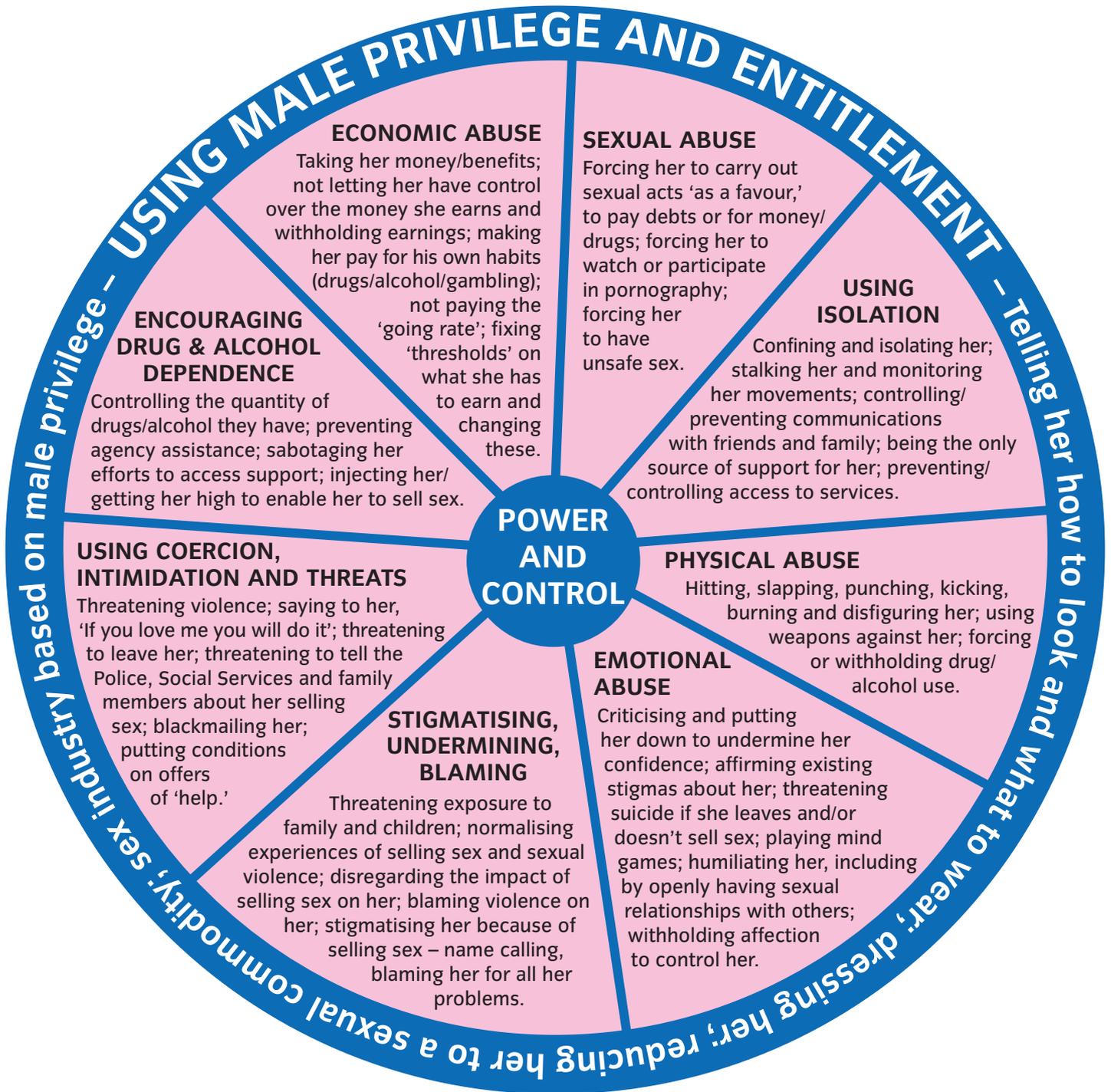
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TEXAS COUNCIL ON FAMILY VIOLENCE

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 Phone: 512/794-1133 • Fax: 512/784-1199
www.tcfv.org



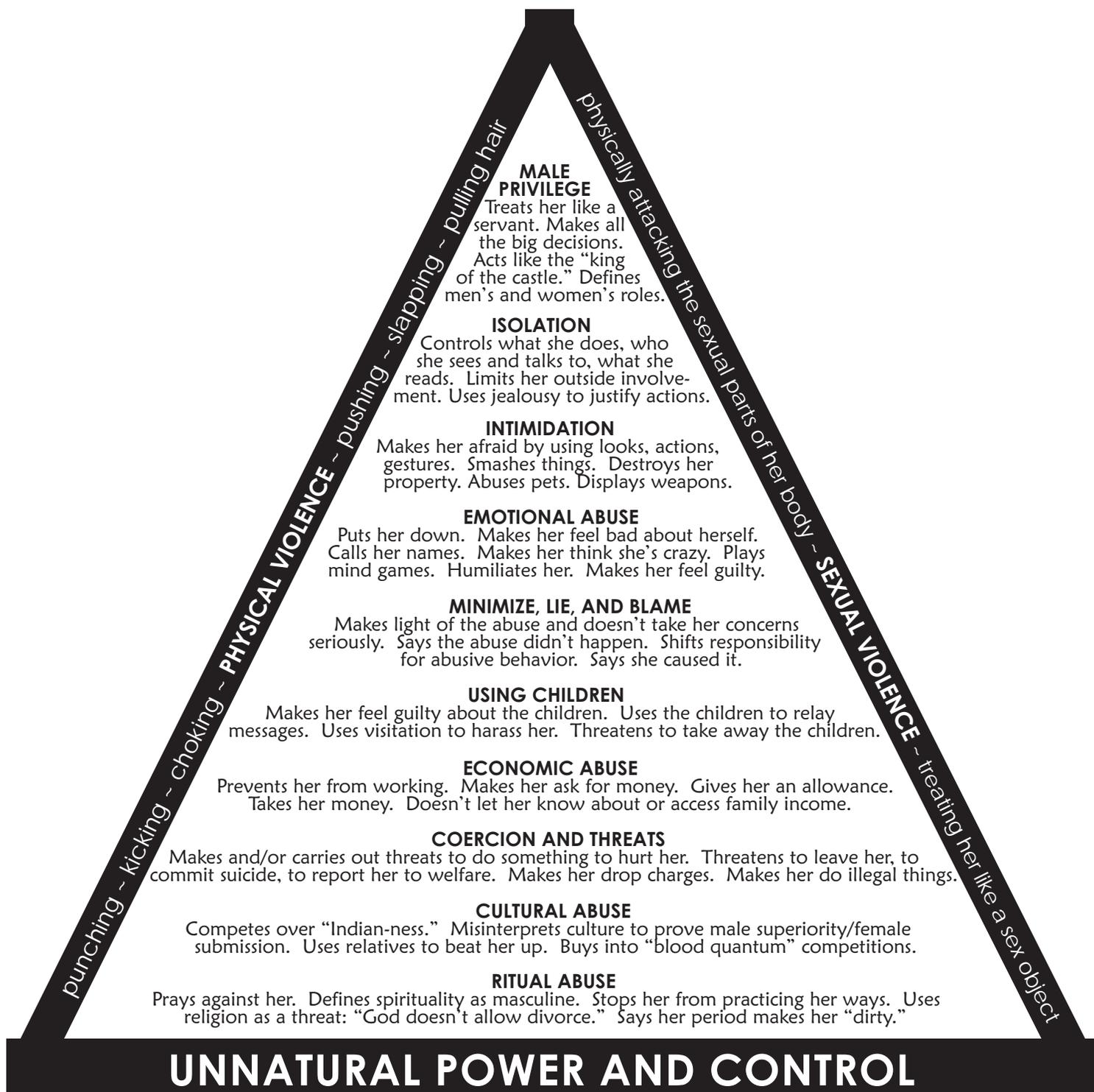
POWER & CONTROL WHEEL FOR WOMEN INVOLVED IN STREET PROSTITUTION



Copyrighted to Safe Exit at Toynbee Hall, with thanks to the London Borough of Tower Hamlets Domestic Violence Team and the Stella Project.

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VIOLENCE AGAINST NATIVE WOMEN: BATTERING



Produced and distributed by:

Developed by:
Sacred Circle - National Resource
Center to End Violence Against
Native Women



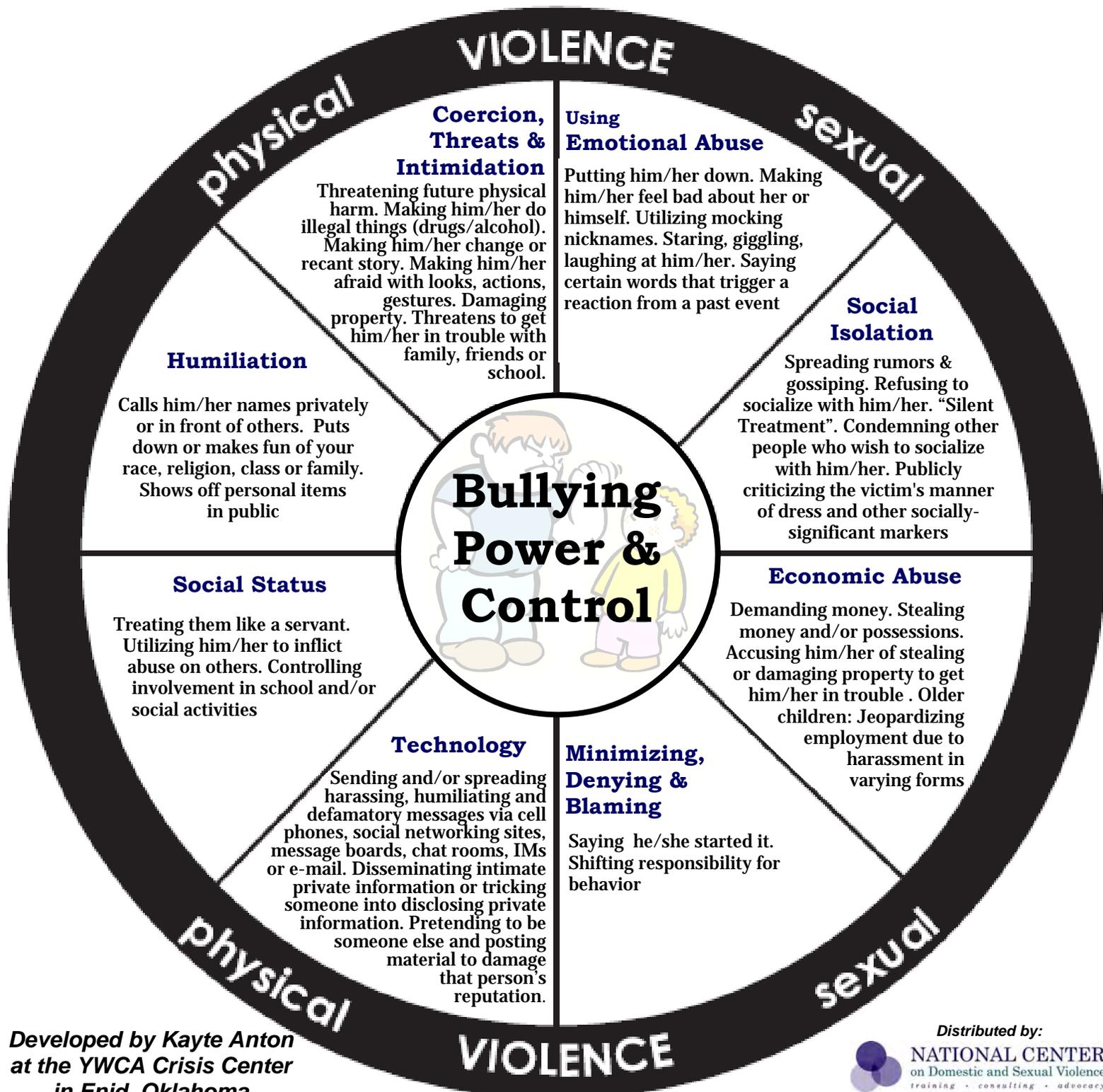
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BULLYING POWER & CONTROL WHEEL

Bullying is defined as a conscious, willful, deliberate and repeated hostile activity perpetrated by an abuser who possesses more physical and/or social power and dominance than the victim. It is frighteningly clear that when many normal people gain a measure of power over others they often cannot resist the urge to abuse it and treat those below them with cruelty, indignity and contempt.

Mediation between the bully and victim is not possible; in a true case of bullying, putting them together to work out their problems would simply re-victimize the victim. Although bullying is generally thought of as a childhood problem it takes many forms across the lifespan: sexual harassment, gang attacks, dating violence, assault, domestic violence, child abuse, harassment in the workplace, and elder abuse.

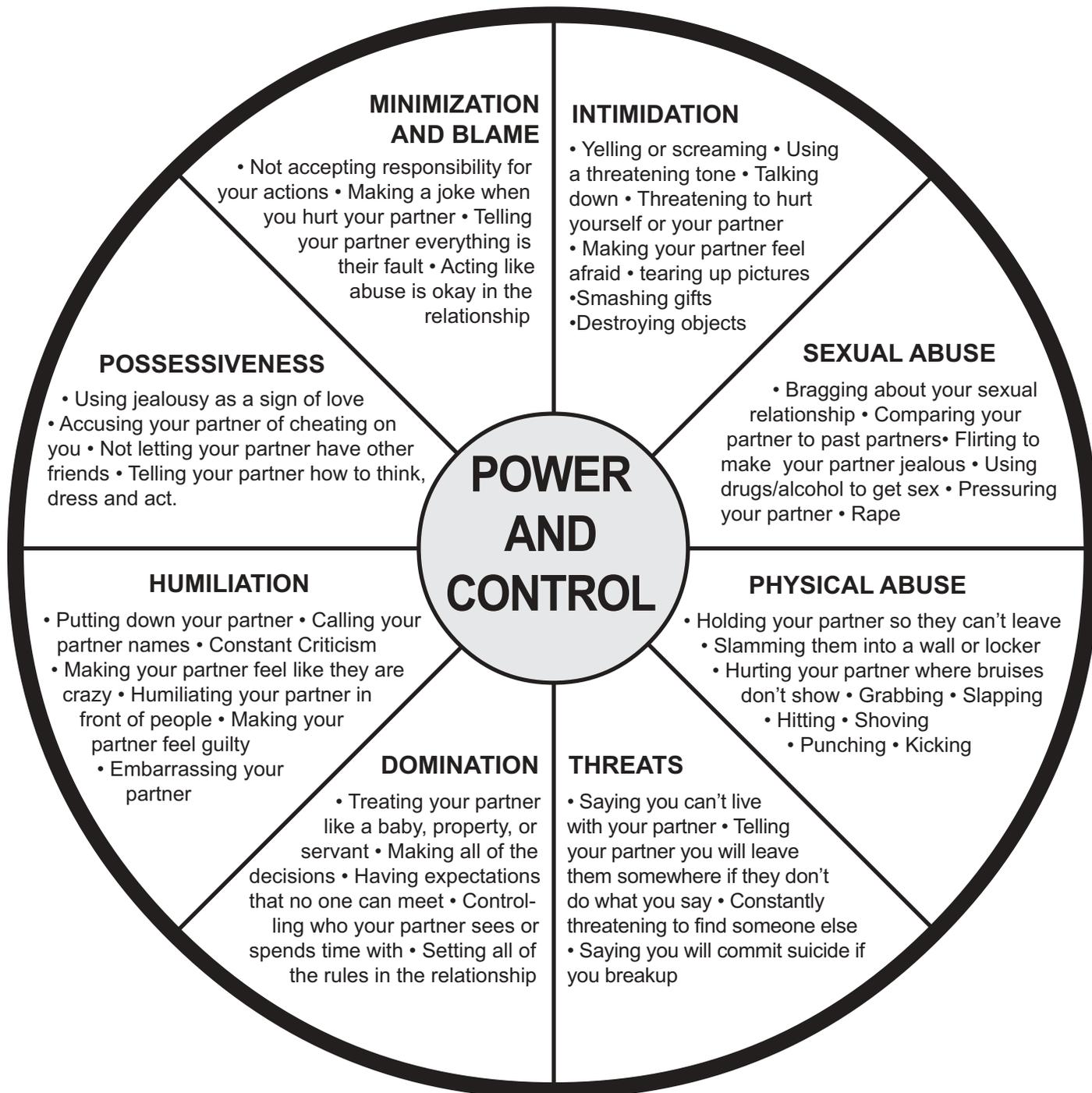


**Developed by Kayte Anton
at the YWCA Crisis Center
in Enid, Oklahoma**

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POWER & CONTROL in Dating Relationships

When one person in a relationship repeatedly scares, hurts or puts down the other person, it is abuse. The Power & Control Wheel lists examples of each form of abuse. Remember, abuse is much more than slapping or grabbing someone.



A relationship full of control is really out of control.

Adapted with permission from the "Power & Control and Equality Wheels," developed by Domestic Abuse Intervention Project, Duluth, MN.

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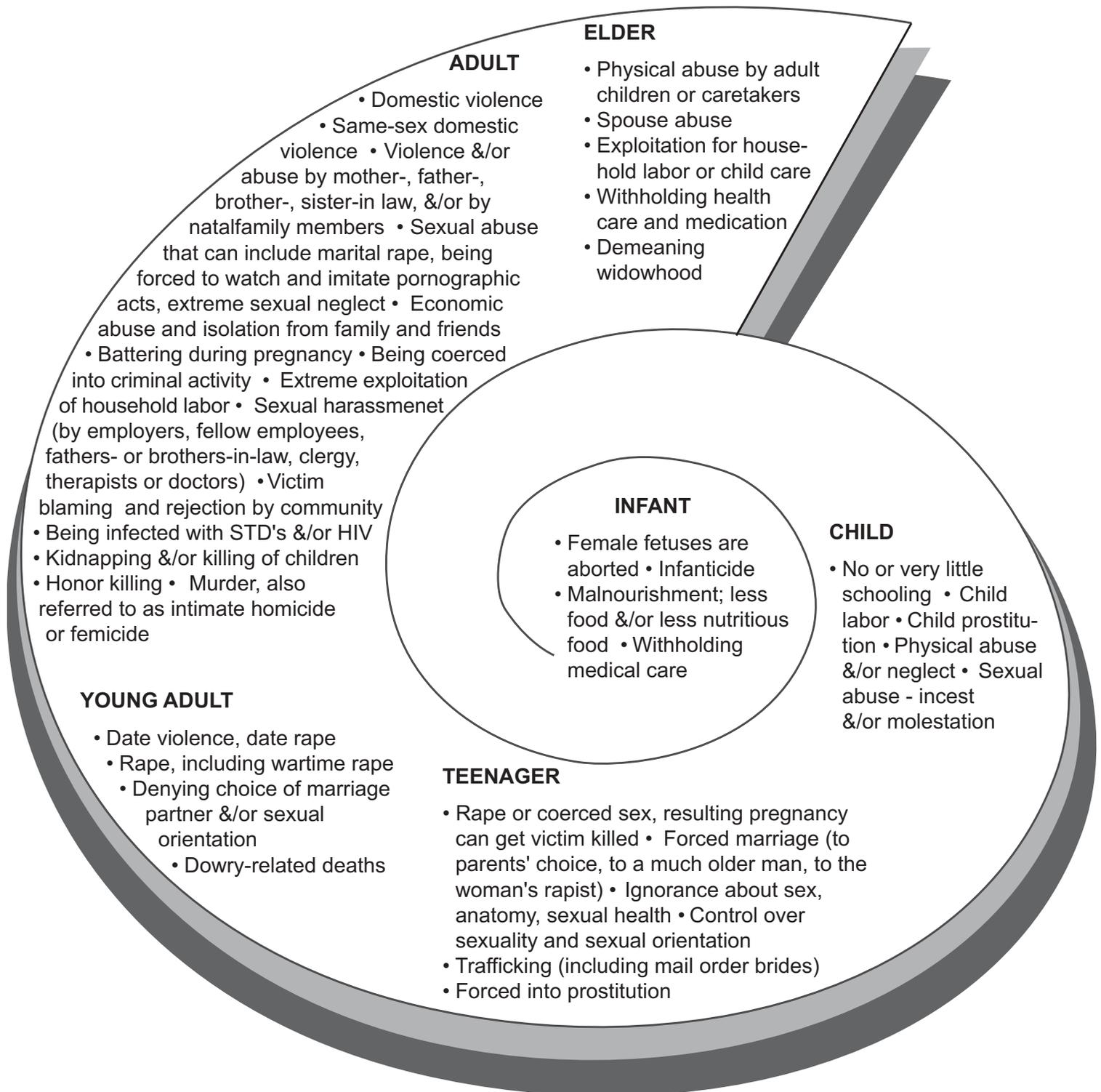


UNITED AGAINST VIOLENCE

Kansas Coalition Against Sexual and Domestic Violence
220 SW 33rd Street • Topeka, KS 66611
785-232-9784 • FAX: 785-266-1874 • E-Mail: coalition@kcsdv.org

ABUSES ENDURED BY A WOMAN DURING HER LIFE CYCLE

Although some of these occur at a specific stage in a woman's life, most can reoccur or continue throughout her life.



Developed by: **ASIAN & PACIFIC ISLANDER INSTITUTE ON DOMESTIC VIOLENCE**

450 Sutter Street, Suite 600, San Francisco CA, 94108

415-954-9988 x 315 FAX: 415-954-9999

www.apiahf.org/apidvinstitut

apidvinstitute@apiahf.org

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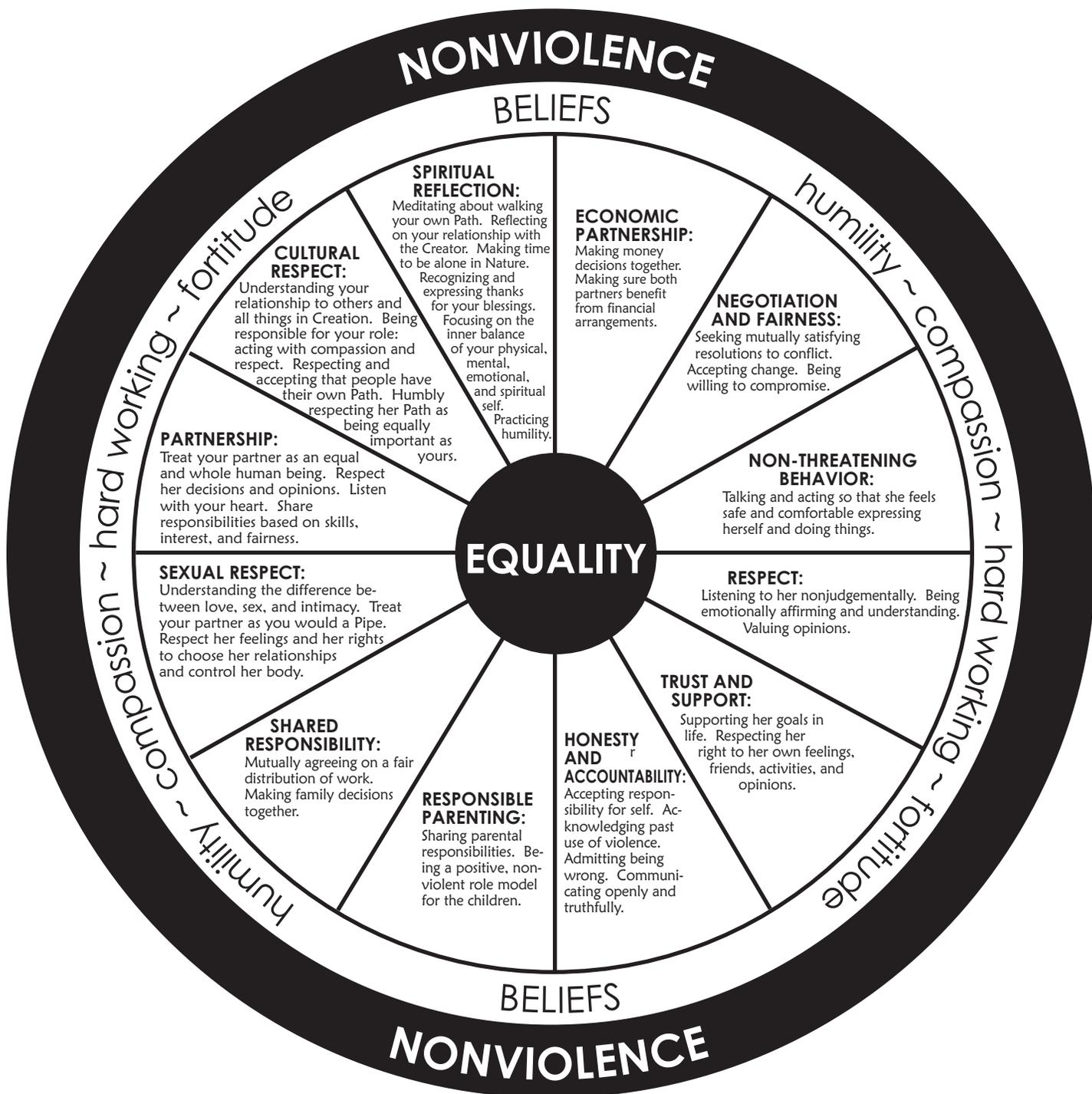
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NATURAL LIFE-SUPPORTING POWER

Equality is a natural life-supporting power that is grounded in spirituality.



Produced by Sacred Circle -
National Resource Center to End Violence
Against Native Women, a project of Cangleska, Inc.
Based on DAIP's model.

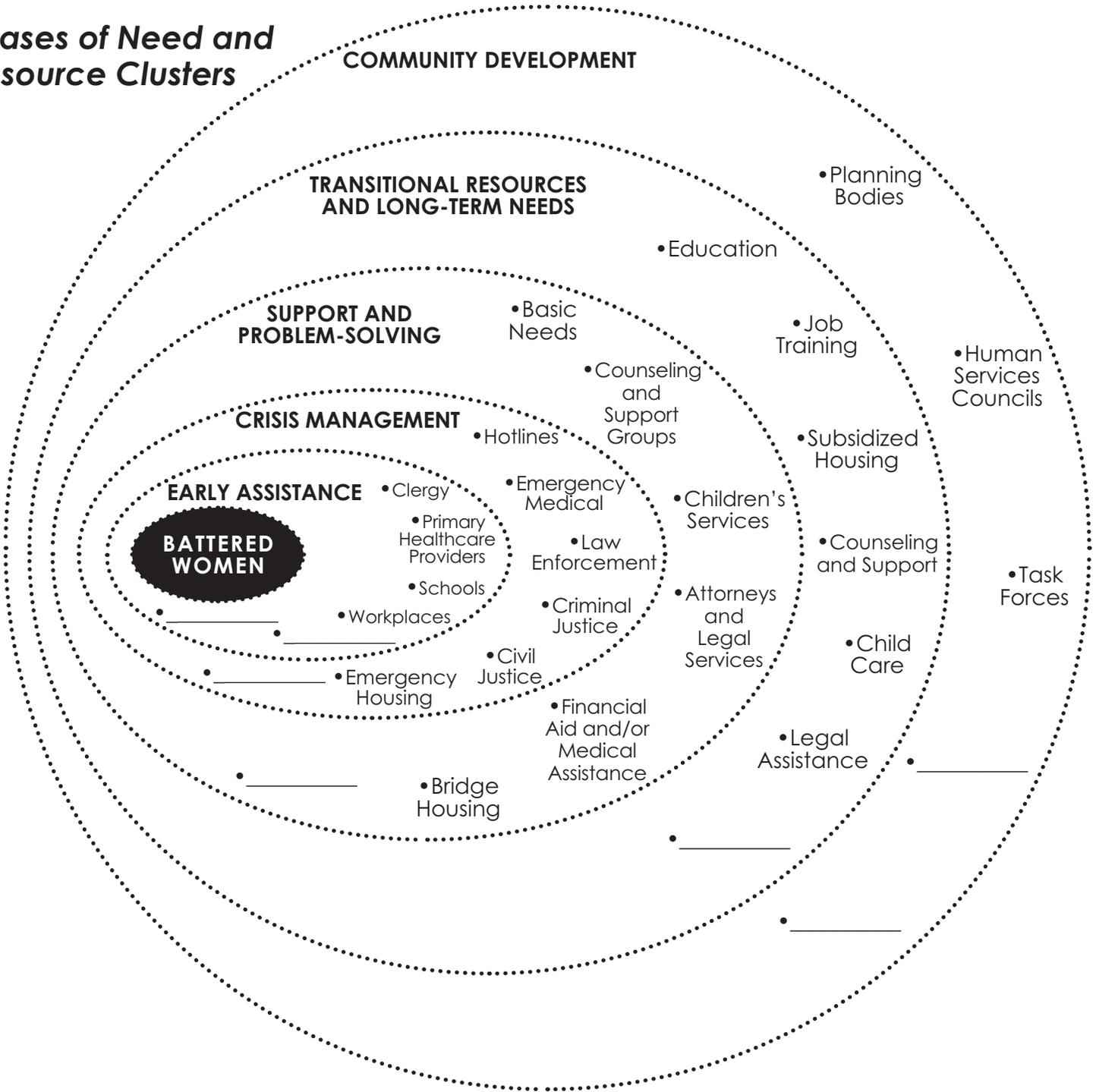
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CONTINUUM OF CARING: COMMUNITY-BASED RESOURCES FOR BATTERED WOMEN

Phases of Need and Resource Clusters



Developed from:
THE COMMUNITY AUDIT: A Resource for
Battered Women's Advocates,
Pennsylvania Coalition Against
Domestic Violence (1997)

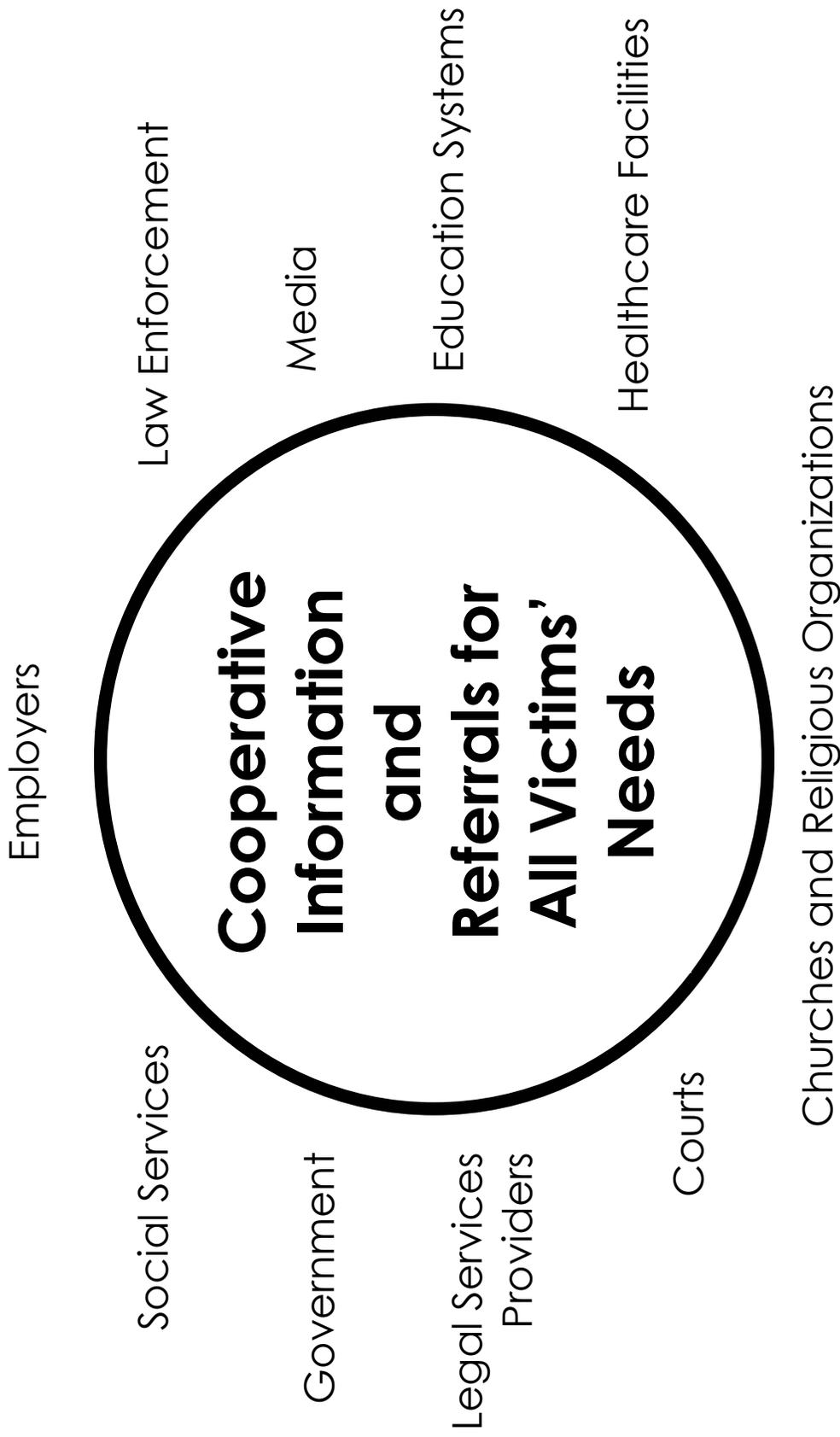
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IDEAL INSTITUTIONAL RESPONSE

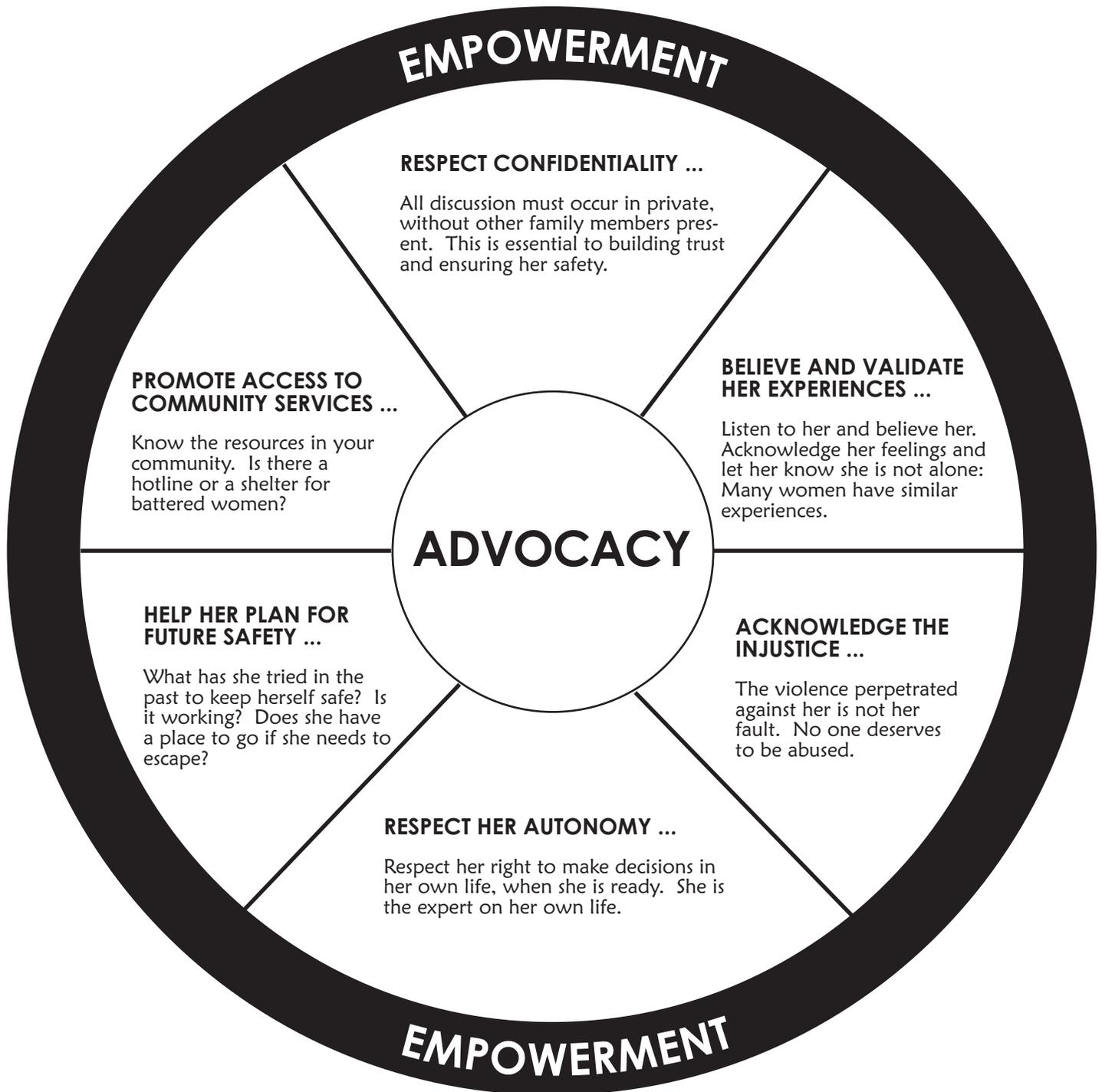


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ADVOCACY WHEEL



SUCCESSFUL COLLABORATION WHEEL

When to collaborate?

The general rule is that law enforcement agencies or personnel should engage in collaboration with other organizations or individuals when stakeholders have a common, long-term goal; are committed to working together as a team; and cannot achieve the goal more efficiently as independent entities. Not all law enforcement relationships must be collaborative, nor should they strive to be. Under some circumstances, it may be appropriate for law enforcement personnel just to establish a good communication plan. Under other circumstances, cooperation between two individuals may be sufficient. Perhaps coordination between two agencies to avoid duplication of effort is all that is required. Collaboration is, however, critical for many community policing endeavors.



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Reproduced from "Collaboration Toolkit: How to Build, Fix, and Sustain Productive Partnerships," by Tammy A. Rinehart, Anna T. Laszlo, and Gwen O. Briscoe, Ph.D., Community Oriented Policing Services, U.S. Dept. of Justice, Washington, D.C.: 2001



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COORDINATED COMMUNITY ACTION MODEL

This Model demonstrates, in abbreviated form, ways communities can accountably act to support battered women and children, and hold batterers accountable for their behavior. It is not a definitive representation. This Model primarily identifies heterosexual males as perpetrators of domestic violence (DV), as they comprise 95% of the batterers in this country. This Model was developed by Mike Jackson and David Garvin with the feedback of over 118 reviewers. We are grateful for their input, and acknowledge the Domestic Abuse Intervention Project for the wheel format. Permission to reproduce is given if there are no changes and credit is given. Please make copies and distribute them for your public education efforts. We welcome your feedback for future editions.



Developed by:
Domestic Violence Institute of Michigan
P.O. Box 130107, Ann Arbor, MI, 48113-0107,
(313) 769.6334

Inspired and adapted from the "Power & Control Wheel" developed by the Domestic Violence Intervention Project, 202 East Superior Street, Duluth, MN, 55802, (218) 722.4134

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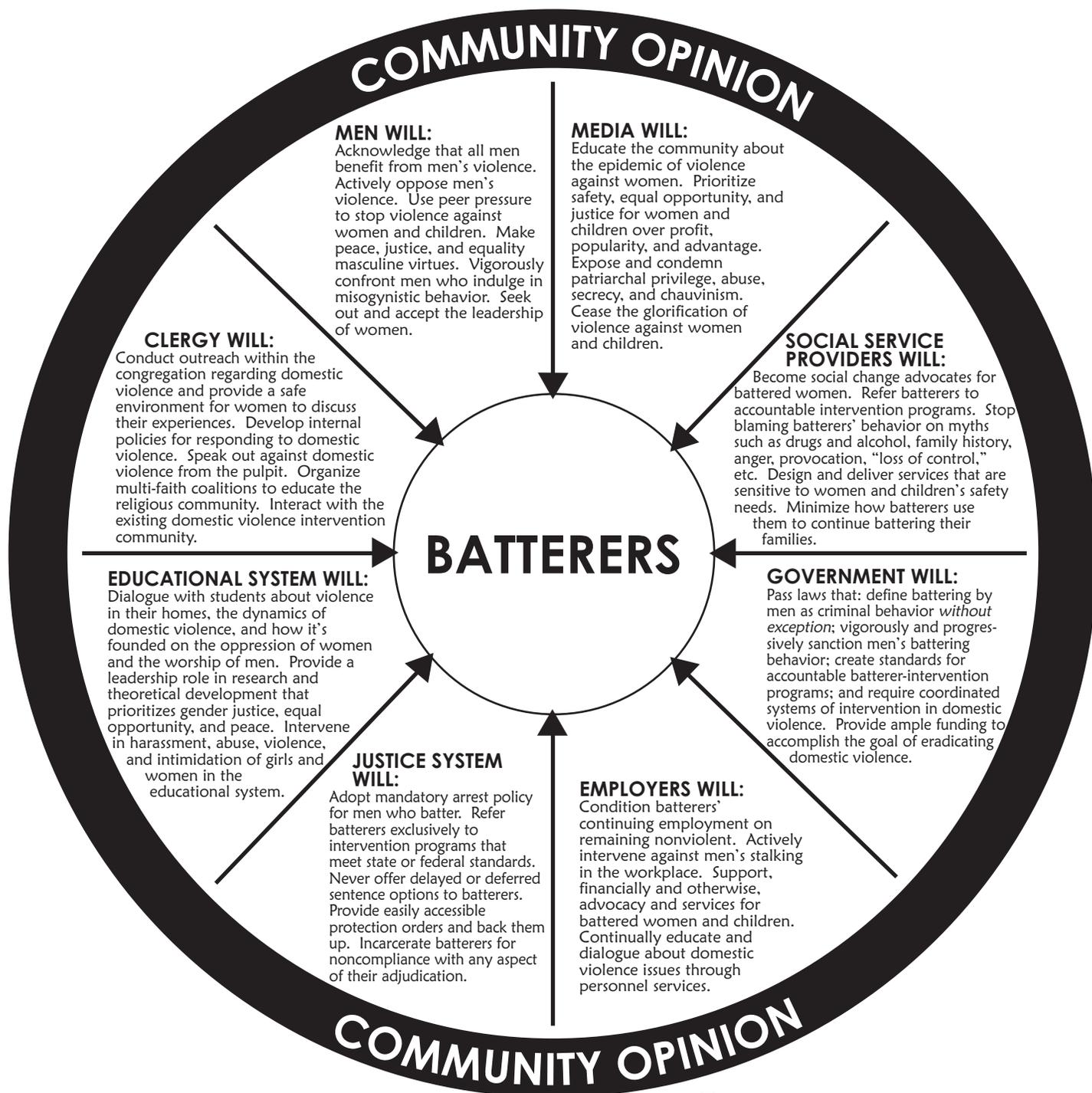


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COMMUNITY ACCOUNTABILITY WHEEL

This wheel *begins* to demonstrate the ideal community response to the issue of domestic violence. Community opinion, which strongly states that battering is unacceptable, leads all of our social institutions to expect full accountability from the batterer by applying appropriate consequences. This wheel was developed by Mike Jackson and David Garvin of the Domestic Violence Institute of Michigan (P.O. Box 130107, Ann Arbor, MI 48113, tel: 313.769.6334).



Inspired and adapted from the "Power & Control Equality Wheels" developed by: Domestic Abuse Intervention Project
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This wheel demonstrates the ideal response of community faith leaders to domestic violence.

UNITED TO END DOMESTIC VIOLENCE

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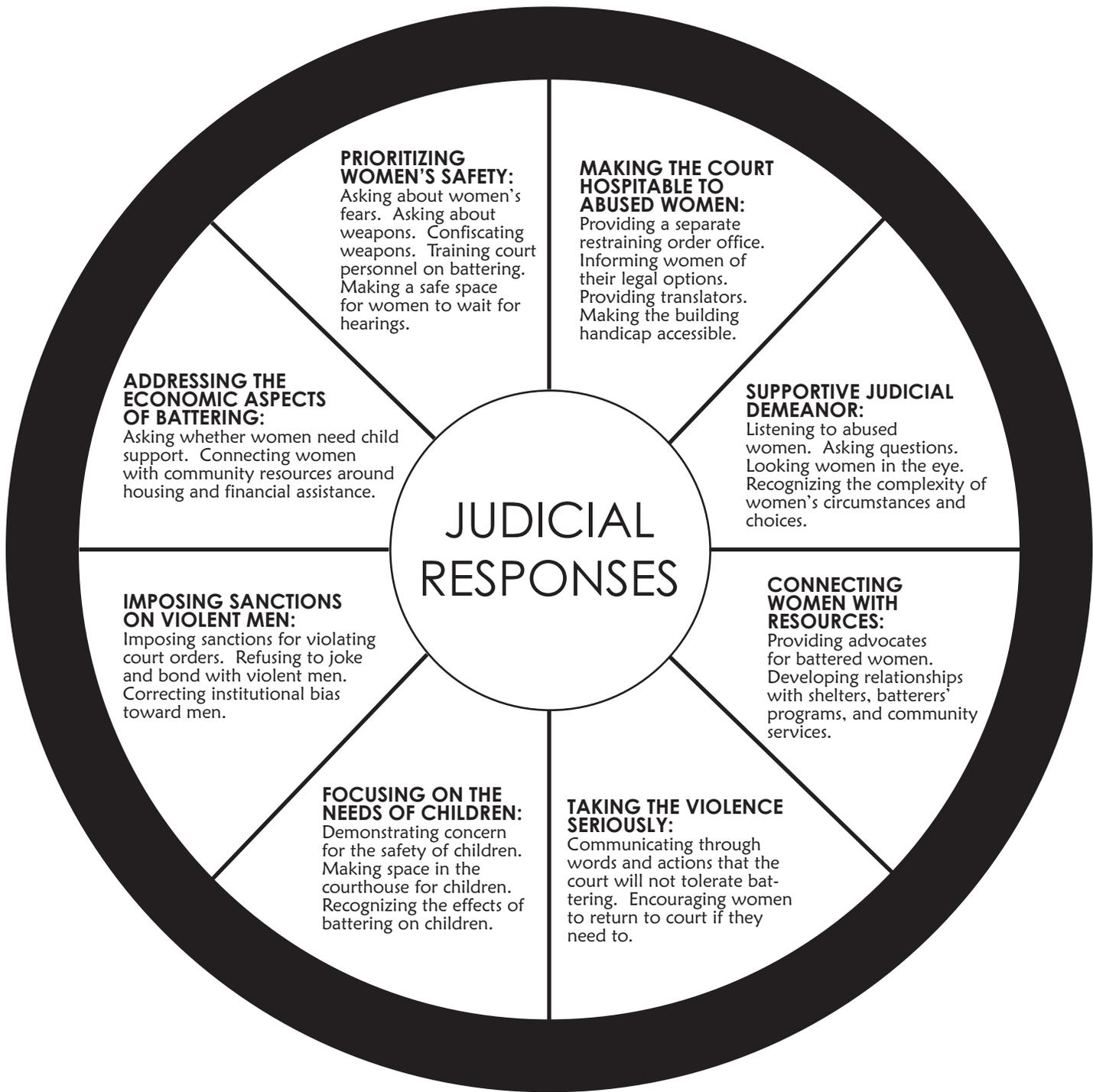
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JUDICIAL RESPONSES THAT EMPOWER BATTERED WOMEN



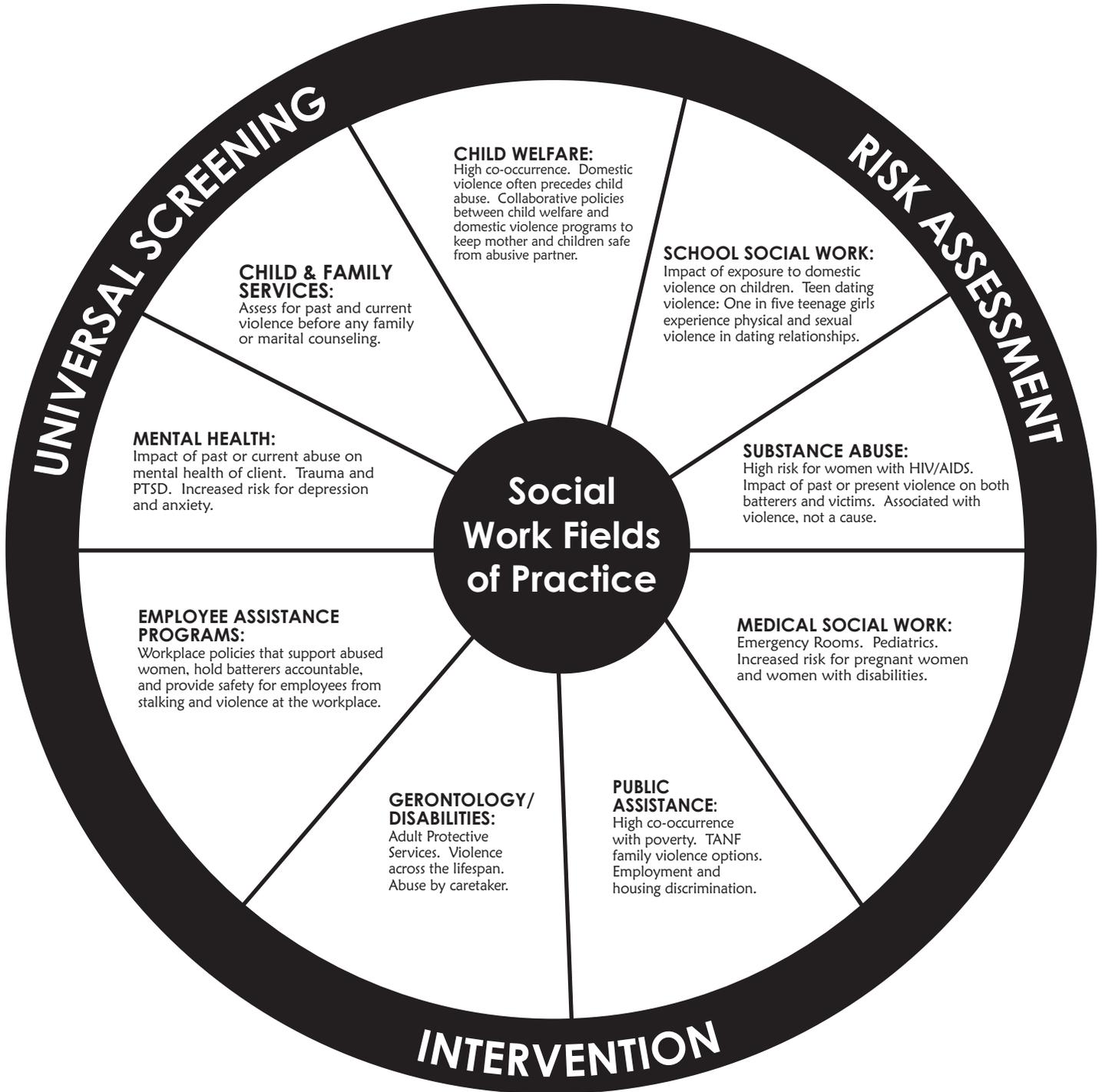
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James Ptacek, "Battered Women in the Courtroom: The Power of Judicial Responses," Northeastern University Press, 1999.

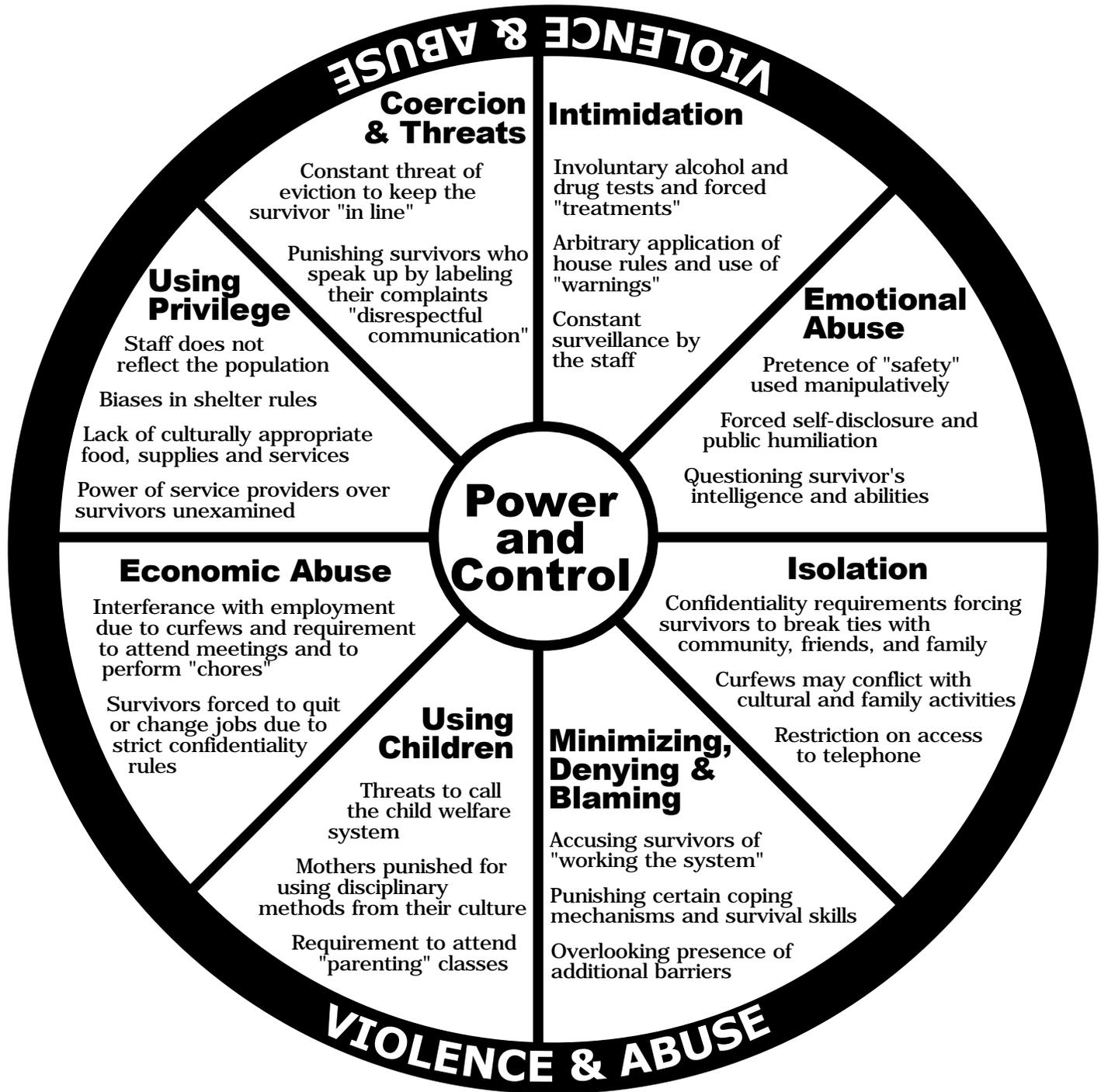


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DOMESTIC VIOLENCE: A CROSS-CUTTING ISSUE FOR SOCIAL WORKERS



Abusive Power and Control within the Domestic Violence Shelter



© 2002 Emi Koyama & Lauren Martin

This "power and control wheel" was created by Emi Koyama and Lauren Martin to illustrate how domestic violence shelters may inadvertently abuse power and control over survivors who seek services from them. In no way is this meant to discount the fact that advocates have been doing, and continue to do, extremely important and life-saving work. Rather, it is meant to incite discussion as to what we still need to work on in our empowerment-based and social change advocacy. Please contact **Survivor Project** at (503) 288-3191 or info@survivorproject.org if you are interested in distributing this wheel.



APPENDICES

APPENDIX: DEFINITIONS

Child Sexual Abuse: Any sexual behavior between a child and someone who has power over the child is sexual abuse. This is true even if the child agreed to participate. The difference in age and power between a child and an older person makes informed consent impossible. Examples of sexual behaviors that constitute abuse include touching or fondling in a sexual way by an older person, asking the child to touch the older person in a sexual way, and asking the child to look at pornographic movies or magazines, undress or pose in a sexual manner for a photo.

Chronic Homelessness: HUD's definition of a person who is "chronically homeless" is an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has at least four episodes of homelessness in the past three years. In order to be chronically homeless, a person must have been sleeping in a place not meant for human habitation – e.g., living on the streets – or in an emergency homeless shelter (National Alliance to End Homelessness, 2007).

Complex Trauma: A term used by mental health professionals to refer to a condition that can result from prolonged and repeated abuse, especially if the abuse began in early childhood or came from multiple sources (Herman, 1997, 2009; Warshaw, 2010). Complex trauma involves traumatic stressors that are repetitive or prolonged; involve direct harm and/or neglect and abandonment by caregivers or ostensibly responsible adults; occur at developmentally vulnerable times in the victim's life, such as early childhood; and have great potential to severely compromise a child's development (Courtois and Ford, 2009). Complex trauma is also referred to variously as *complex traumatic stress* or *complex psychological trauma* (Courtois & Ford, 2009) and *complex posttraumatic stress disorder* (Herman, 1997, 2009).

Disability: Under the Americans With Disabilities Act (ADA), an individual is considered to have a "disability" if she or he has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment, or is regarded as having such an impairment. Examples offered by ADA of major life activities include seeing, hearing, speaking, walking, breathing, performing manual tasks, learning, caring for oneself, and working. Disabilities that fall under this definition range from epilepsy, paralysis and HIV infection to a substantial hearing or visual impairment, intellectual impairment, and various learning disabilities (U.S. Equal Employment Opportunity Commission, 2002).

Domestic Violence: Domestic violence as defined by the American Psychological Association (APA, 1996) is: "a pattern of abusive behaviors including a wide range of physical, sexual, and psychological maltreatment used by one person in an intimate relationship against another to gain power unfairly or maintain that person's misuse of power, control and authority." Domestic violence, simply stated, is an attempt to control the behavior of an intimate partner. Abuse is a misuse of power that uses the bond of

intimacy, trust, and dependency to make an intimate partner, man or woman, feel unequal, powerless and unsafe (IDHS, 2000).

DSM-IV-R: The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Revised, published by the American Psychiatric Association. The manual provides a common language and standard criteria for the classification of mental disorders, and is used in the United States and in varying degrees around the world by clinicians, researchers, health insurance companies and others.

Empowerment Philosophy: An approach favored by advocates who work with domestic violence and sexual assault survivors, this philosophy acknowledges competency and offers support, resources, advocacy, information and education, striving to equalize power between individuals and their environment. Emphasis is on safety and empowerment, support and access to resources, accountability for abusers and perpetrators, and social change.

Historical Trauma: Cumulative trauma – collective and compounding emotional and psychological wounding – both over the life span and across generations. In other words, it is trauma upon trauma that occurs in history to a specific group of people, causing emotional and mental wounding both during their lives and the generations that follow (AIFACS, n.d.).

Homelessness: In general, the U.S. Department of Housing and Urban Development (HUD) divides “residential instability” into two broad categories: “literally homeless” and “precariously housed” (HUD, 2007). “*Literally homeless*” includes people who for various reasons have found it necessary to live in emergency shelters or transitional housing for some period of time. This category also includes people who sleep in places not meant for human habitation (for example, streets, parks, abandoned buildings, and subway tunnels).

Human Trafficking: Human trafficking is best understood as modern-day slavery. Children and adults are trafficked through force, fraud, or coercion into sweatshops, domestic servitude, commercial sex, farm labor, begging, construction and many other forms of labor (Song & Thompson, 2005).

Incarceration: For purposes of this document, “incarceration” means being held in a state or federal prison, local jail, work camp or youth detention center.

Intergenerational Grief: Grief passed on from the generation experiencing the trauma to their children (the next generation) even though the children may not be aware of or have direct experience of the actual traumatic event. Unresolved grief can be passed on from parents to children to grandchildren and so on (AIFACS, n.d.).

Internalized Oppression: A form of oppression that occurs when individuals absorb society’s attitudes toward their group and direct those negative attitudes toward

themselves (Green, 2007). One can think of internalized oppression as the internalized police officer that keeps people in their socially prescribed place (Roy, 2007).

Mental Illness: The National Alliance on Mental Illness defines mental illnesses as medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Examples of serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post traumatic stress disorder and borderline personality disorder (NAMI, 2009).

Motivational Interviewing: An counseling approach which helps people change harmful behavior such as alcohol or drug abuse by exploring and resolving the ambivalence most people feel when they seek to make major changes in their lives (Rollnick & Miller, 1995). Emphasis is on respecting individuals' right to make their own decisions as they are ready to do so, which makes the approach compatible with the empowerment approach favored by victims' advocates.

Multi-Abuse Trauma: A term used by some advocates who serve survivors of domestic violence and sexual assault. It refers to the multiple layers of oppression and trauma that may be experienced when an individual is impacted by multiple co-occurring issues that negatively affect safety, health or well-being. While advocates are not therapists or clinicians, the role of the advocate includes identifying barriers to safety, autonomy, services and justice. When multiple barriers exist, advocates should consider the possibility that the person seeking our help is a survivor of *multi-abuse trauma*. The term multi-abuse trauma describes not what is wrong with a person but acknowledges *the many forms of harm that have happened* to an individual. This framework makes it possible to understand behaviors that on the surface don't make sense to us but make sense to those for whom we provide advocacy. It also provides a framework to explore multiple options with the people we serve.

Neurodiversity: The term, coined by autism activist Judy Singer, refers to a number of conditions resulting from neurological differences such as autism, attention deficit hyperactivity disorder, dyslexia, intellectual impairments, schizophrenia and mood disorders. The emphasis in neurodiversity is placed on accepting differences, with people encouraged to focus on strengths associated with these conditions rather than focusing solely on "deficits" (Armstrong, 2010).

Postcolonization Stress Disorder: Condition which results from struggling with racism and cultural imperialism, as well as the imposition of mainstream culture as dominant and superior (Comas-Diaz, 2007). Psychological effects include depression, shame, rage and post-traumatic stress disorder.

Post Incarceration Syndrome: A set of symptoms present in many people who are currently incarcerated or recently released, caused by being subjected to prolonged incarceration in environments of punishment with few opportunities for education, job training, or rehabilitation. The symptoms are most severe in people subjected to prolonged solitary confinement and severe institutional abuse (Gorski, 2001).

Precariously Housed: People on the brink of homelessness. Individuals may be doubled up with friends and relatives or paying extremely high proportions of their resources for rent, and are often characterized as being at imminent risk of becoming homeless (HUD, 2007).

Sexual Assault/Sexual Abuse: Sexual assault and sexual abuse refer to any sexual contact without consent. Examples include rape, attempted rape, unwanted touching and child sexual abuse. The abuser could be a stranger, date, friend, lover or even a spouse or relative. Sexual abuse is often involved in domestic violence, and may be one way batterers abuse their partners.

Sex Trafficking: A subset of human trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age (Song & Thompson, 2005).

Social Model Of Disability: The *social model* of disability, based on a definition by the World Health Organization, identifies systemic barriers –inaccessible buildings, negative attitudes that result in prejudice and discrimination, and inadequate support – as the main factors in disabling people. The social model is held up as a contrast to the *medical model* of disability, which focuses on individual “deficits.” Proponents of the social model argue that while physical, sensory, intellectual, or psychological variations may cause individual functional limitation or impairments, these do not have to lead to disability unless society fails to accommodate and include people regardless of their individual differences (ASI, 2010).

Societal Abuse: Societal abuse refers to the disadvantages that a group experiences as a result of unjust social structures (Benbow, 2009). Examples include sexism, racism, homophobia and other forms of discrimination that grant variable human worth to individuals based on such factors as race or ethnicity, gender, sexual orientation, disability or other status. Societal abuse is perpetuated by society through its dominant culture and values, or by its tendency to accept abusive behavior (Schwartz-Kenney et. al, 2001).

Substance Use Disorders: Substance use disorders involve dependence on, or abuse of, alcohol or other drugs, including the overuse or non-medical use of prescription drugs. Substance abuse is a destructive pattern of use of drugs – including alcohol – which leads to clinically significant (social, occupational or medical) impairment or distress. Often the substance use continues in spite of significant life problems related to that use. When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of the substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of the substance), it is likely that the person has progressed from abuse to dependence. *Adapted by the Illinois Department of Human Services Domestic Violence/Substance Abuse Interdisciplinary Task Force from definitions developed by the American Psychiatric Association and the American Society for Addiction Medicine (IDHS, 2000).*

Trauma Informed Care: Care by mental health and other professionals that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services (Huckshorn, 2004).

Type I Trauma: Trauma caused by a single incident such as a serious car accident, a natural disaster, or a one-time episode of abuse or assault, and often involved in simple post-traumatic stress disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Revised*, published by the American Psychiatric Association (Courtois & Ford, 2009).

Type II Trauma: Repetitive trauma such as child physical or sexual abuse, severe domestic violence or community violence that is ongoing and chronic (Courtois & Ford, 2009), and often involved in complex trauma.

Wellness Recovery Action Plan™ (WRAP): Used by mental health professionals, WRAP is a tool for promoting wellness and a structured system for monitoring symptoms through “Advance Directives.” An example of an advance directive: “If I cannot advocate for myself, please do this ... and not this. Involve this person ... and not this one.” Goals of a WRAP plan include teaching recovery and self-management skills and strategies, promoting wellness, reducing invasive therapies, decreasing the incidence of serious mental health challenges and decreasing stigma (Warshaw & Pease, 2010a).

APPENDIX: ADDITIONAL RESOURCES

For advocates and other providers who want more in-depth information on the topics discussed in *Real Tools: Multi-Abuse Trauma*, this section lists publications, Web sites, organizations and community support groups that are particularly good sources of information and help.

Alaska Network on Domestic Violence and Sexual Assault

The Alaska Network on Domestic Violence and Sexual Assault promotes and sustains a collective movement to end violence and oppression through social change. We are a nonprofit, membership corporation composed of 17 programs statewide that provide services to victims of domestic violence and sexual assault, offender services, and adult crisis intervention services.

Collectively, we believe that the elimination of interpersonal and societal violence is most effectively advanced through: grass roots efforts of local-based programs; communities that hold abusers accountable; and networking and coalition building at the local, state, and national levels.

Visit our Web site to access facts and statistics, research and other information about domestic violence and sexual assault. Also available on our Web site are Internet and computer safety tips, information about violent crimes compensation, useful links to other organizations that address interpersonal violence, and information about our various programs and projects.

In addition, ANDVSA produces a number of excellent publications that are available free of charge. These publications can be downloaded from our Web site, and some can be ordered from ANDVSA as hard copies.

Our Legal Advocacy Project publications include:

Domestic Violence & Guns: A Guide to the Laws That Can Remove Guns from a Dangerous Abuser. This brochure outlines how the law can help you be safer in six steps.

Domestic Violence Protective Orders: How to Get Out-of State Enforcement. The Violence Against Women Act makes it possible to get your domestic violence protective order enforced in other states. This brochure helps you learn how.

Women's Legal Rights Handbook, 2007 Edition is designed for any woman navigating the legal system on topics such as employment, bankruptcy, credit, debt collection, inheritance, criminal law, violent crimes, name changes, reproductive rights, divorce,

ANDVSA MEMBER PROGRAMS

Advocates for Victims of Violence

P.O. Box 524
Valdez, AK 99686
Office: 907-835-2980
Fax: 907-835-2981
Hotline: 800-835-4044 / 907-835-2999

Abused Women's Aid in Crisis, Inc.

100 W. 13th Ave
Anchorage, AK 99501
Office: 907-279-9581
Fax: 907-279-7244
Hotline: 907-272-0100

Aiding Women in Abuse and Rape Emergencies

P.O. Box 20809
Juneau, AK 99802
Office: 907-586-6623
Fax: 907-586-2479
Hotline: 800-478-1090 / 907-586-1090

Arctic Women In Crisis

P.O. Box 69,
Barrow, AK 99723
Office: 907-852-0261
Fax: 907-852-2474
Hotline: 800-478-0267 / 907-852-0267

Bering Sea Women's Group

P.O. Box 1596
Nome, AK 99762
Office: 907-443-5491
Fax: 907-443-3748
Hotline: 800-570-5444 / 907-443-5444

Cordova Family Resource Center

P.O. Box 863
Cordova, AK 99574
Office: 907-424-5674
Fax: 907-424-5673
Hotline: 866-790-4357 / 907-424-4357

Kodiak Women's Resource and Crisis Center

P.O. Box 2122
Kodiak, AK 99615
Office: 907-486-6171
Fax: 907-486-4264
Hotline: 907-486-3625

The LeeShore Center

325 S. Spruce Street
Kenai, AK 99611
Office: 907-283-9479
Fax: 907-283-5844
Hotline: 907-283-7257

Maniilaq Family Crisis Center

P.O. Box 38
Kotzebue, AK 99752
Office: 907-442-3724
Fax: 907-442-3985
Hotline: 907-442-3969

Safe and Fear-Free Environment

P.O. Box 94
Dillingham, AK 99576
Office: 907-842-2320
Fax: 907-842-2198
Hotline: 800-478-2316 / 907-842-2316

Sitkans Against Family Violence

P.O. Box 6136
Sitka, AK 99835
Office: 907-747-3370
Fax: 907-747-3450
Hotline: 800-478-6511 / 907-747-3370

South Peninsula Haven House

3776 Lake Street, Suite 100
Homer, AK 99603
Office: 907-235-7712
Fax: 907-235-2733
Hotline: 800-478-7712 / 907-235-8101

ANDVSA MEMBER PROGRAMS

Tundra Women's Coalition

P.O. Box 2029
Bethel, AK 99559
Office: 907-543-3444
Fax: 907-543-3752
Hotline: 800-478-7799 / 907-543-3456

Women in Safe Homes

P.O. Box 6552
Ketchikan, AK 99901
Office: 907-225-9474
Fax: 907-225-2472
Hotline: 800-478-9474 / 907-225-9474

Unalaskans Against Sexual Assault & Family Violence

P.O. Box 36
Unalaska, AK 99685
Office: 907-581-1500
Fax: 907-581-4568
Hotline: 800-478-7238 / 907-581-1500

OTHER VICTIM-SERVICE

Alaska Immigration Justice Project

431 West 7th Avenue, Suite 208
Anchorage, AK 99501
Office: 907-279-2457
Fax: 907-279-2450
www.akijp.org

Alaska Legal Services Corporation

1016 West 6th Avenue, Suite 200
Anchorage, AK 99501
Office: 907-272-9431
Fax: 907-279-7417
www.alsc-law.org

Alaska Native Justice Center

3600 San Jeronimo Drive, Suite 264
Anchorage, AK 99508
Office: 907-793-3550
Fax: 907-793-3570
www.anjc.net

University of Alaska – Anchorage Center for Human Development

2702 Gambell Street, Suite 103
Anchorage, AK 99503
Office: 907-272-8270
Fax: 907-274-4802
www.alaskachd.org

Alaska Native Women's Coalition

P.O. Box 73505
Fairbanks, AK 99701
Office: 907-465-2320

custody, sexual assault and adoption. This publication is also available in hard copy.

The Legal Advocate Training Curriculum provides basic training materials for legal advocates. Please contact us at 586-3650 for a hard copy.

The Volunteer Attorney Manual for Family Law is designed for our pro-bono attorneys

working with family law cases involving domestic violence and sexual assault. Please contact us at 586-3650 for a hard copy of this nationally recognized publication.

Our Training Project publications include:

Getting Safe and Sober: Real Tools You Can Use. An advocacy teaching kit for working with women coping with substance abuse and interpersonal violence (2005 version).

Getting Safe and Sober: Real Tools You Can Use. An advocacy teaching kit for working with women coping with substance abuse, interpersonal violence and trauma (2nd Edition, Revised 2008).

Both of these training manuals are also available in Spanish.

Access the ANDVSA Web site at www.andvsa.org.

Other Publications

Advancing Social Justice through Clinical Practice, a hardback book edited by Etiony Aldarondo, urges human service professionals to work with increased awareness of the toxic effects of social inequities in the lives of people they aim to help. This comprehensive volume seeks to bridge the gap between the psychosocial realities of the individuals we serve and the dominant clinical practices of many mental health professionals. It offers an array of conceptual and practical innovations to address both individual suffering and social inequities fueling this suffering. This is an empowering tool and a must-read for social service professionals who wish to be agents of both individual and social transformation. Available at bookstores or order from amazon.com.

Am I Okay? A Layman's Guide to the Psychiatrist's Bible, by Allen Frances, M.D., and Michael B. First, M.D. Written by two doctors involved in the production of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) – the reference text used by the majority of mental health professional – this book is a user-friendly guide to common mental health concerns written for a lay audience. Available at bookstores or order from amazon.com.

A Woman's Way through the Twelve Steps, by Stephanie Covington. Geared specifically to women in recovery, this book offers a flexible interpretation of the 12 Steps that takes into account the psychological development of women as it relates to addiction and the social and cultural factors that affect women including interpersonal violence issues. *A Woman's Way* acknowledges that recovery raises special issues for women – from questions about sexuality, relationships and everyday life to anxieties about speaking up at mixed gender meetings. Advocates and other providers will want to read this book themselves, as well as recommend it to the recovering women they serve. Available at bookstores or order from amazon.com.

Beyond Labels: Working with Abuse Survivors with Mental Illness Symptoms or Substance Abuse Issues. This manual, created by staff at SafePlace in Austin, TX, takes a comprehensive look at mental health issues and advocate response. The manual provides information, tools and resources to help domestic violence and rape crisis center staff better understand the connection between mental health and trauma. Readers will be better able to work with survivors experiencing mental health and substance abuse issues and how to create a center more welcoming to these survivors. To order a copy of the manual, call 512.267.SAFE (7233) or email Info@SafePlace.org.

Changing the Script: Thinking about Our Relationships With Shelter Residents, by Margaret Hobart for The Washington State Coalition Against Domestic Violence. This article explores how advocates think about their relationship to the people using our programs, and how this impacts service delivery. Hobart discusses the unconscious roles advocates may take on such as “parent” or “rescuer,” how to recognize when this is happening, and how to replace these roles with a more empowering approach. Access the article at www.wscadv.org/docs/Staff_Client_Relationships_in_Shelter.pdf.

Covering Domestic Violence: A Guide for Journalists and Other Media Professionals. This comprehensive guide written by Kelly Starr for the Washington State Coalition Against Domestic Violence is an ideal resource for advocates cultivating relationships with your local news media outlets. While some of the material is Washington-specific, the guide contains valuable general suggestions for media professionals on how to accurately report domestic violence and what to avoid when covering this crime. Download the guide at www.wscadv.org/docs/Media_Guide_2008.pdf and offer it to your favorite reporter.

Healing the Soul Wound: Counseling with American Indians and Other Native Peoples, by Eduardo Duran. Written from an academic perspective, but easily accessible to lay people, this book offers an in-depth explanation of intergenerational grief and historical trauma. It also offers suggestions for providers from the dominant culture on ways to provide appropriate culturally competent services. Available at bookstores or order from amazon.com.

Many Roads, One Journey: Moving Beyond the Twelve Steps, by Charlotte Kasl pioneered a 16-step empowerment approach for overcoming addiction and trauma. Her approach has many parallels to positive psychology, attachment theory, developing resilience, and respecting individual and cultural differences. It also reflects recent knowledge of brain science. The empowerment model has been widely used in the United States and Canada, and many people are finding it helpful for overcoming depression as well as addictions. Kasl states that “while fear may jump-start people into recovery, love and self respect are what helps them heal.” This book is user-friendly for both providers and recovering individuals. Available at bookstores or order from amazon.com.

Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror, by Judith Herman. If you only have time to read one book right now, make it this one. *Trauma and Recovery* brings a new level of understanding to a set of problems

usually considered individually. Herman draws on her own cutting-edge research on domestic violence, as well as on a vast literature of combat veterans and victims of political terror, to show the parallels between private terrors such as rape and public traumas such as terrorism. The book puts individual experience in a broader political frame, arguing that psychological trauma can be understood only in a social context. Available at bookstores or order from amazon.com.

Trauma Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs, written by Sonia D. Ferencik and Rachel Ramirez-Hammond for the Ohio Domestic Violence Network. This manual explains the need for a trauma-informed approach to domestic violence services, and offers a wealth of suggestions for creating a more welcoming environment in shelter programs, as well as helping survivors of trauma feel more empowered. Access the manual at www.odvn.org.

Treating Complex Traumatic Stress Disorders, edited by C.A. Courtois and J.D. Ford. This hardback book takes a comprehensive look at complex trauma stemming from interpersonal violence and discusses effective ways of working with survivors based on the latest research. The Forward is written by Judith Herman, a pioneer in the field. Available at bookstores or order from amazon.com.

Organizations

Accessing Safety Initiative (ASI) is a Vera Institute of Justice Project funded by the Office on Violence Against Women. ASI helps organizations and communities meet the needs of women with disabilities who are victims or survivors of domestic violence, sexual assault and stalking. Access the Web site at www.accessingsafety.org.

Alcohol Drug Help Line Domestic Violence Outreach Project. Begun in 1994, the goal of the project is to help women affected by their own or another's substance abuse find safety, sobriety and wellness. The organization provides outreach and education for women affected by domestic violence, chemical dependency and multi-abuse trauma in shelters, chemical dependency treatment programs and other human service agencies, and provides technical assistance and training to providers addressing multiple abuse issues. To contact, call 206-722-3703 (business line); or 800-562-1240 (toll free for WA State and AK only.) Website: www.adhl.org.

Creating a Circle of Hope to Prevent FASD. The National Organization on Fetal Alcohol Syndrome founded the Circle of Hope Birth Mothers Network (COH-BMN) to prevent Fetal Alcohol Spectrum Disorders (FASD) and provide hope for women who may struggle with addictions, may have used substances while pregnant, or may have a child with FASD. **FASD** is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. FASD affects as many as 40,000 newborns each year in the U.S. Individuals who work with victims of domestic violence or with homeless people are in a

unique position to help educate and prevent FASD, which is completely preventable if women abstain from alcohol during pregnancy or if planning a pregnancy. The COH-BMN is a unique peer-mentoring program that provides support for women both in their recovery and/or through the challenges of parenting a child with FASD. Sharing the guilt and shame over substance use while pregnant is a powerful bond for women who typically have trouble connecting with other women. COH-BMN mentors can assist women who may end up in shelters and assist them with the many struggles of getting back their independence and living future healthy lifestyles. Additionally, the COH provides members with referrals, factual information about FASD and addiction, resources and support for women and families. For more information, visit their Web site at www.nofas.org/coh/.

Domestic Violence & Mental Health Policy Initiative is a national technical assistance center whose overarching goal is to ensure that all survivors of domestic violence and their children who are experiencing abuse-related trauma and/or living with mental illness can access the services that they may need to enhance their safety and well-being. DVMHPI has created a ***National Training and Technical Assistance Center on Domestic Violence, Trauma and Mental Health***, funded by the US Department of Health and Human Services, Administration on Children, Youth and Families. The new Center will provide the resources, tools and consensus building opportunities necessary to fill the critical gap in services for survivors with unmet mental health and advocacy needs, to develop more comprehensive and culturally-relevant responses to the range of trauma-related issues faced by domestic violence survivors and their children, and to develop strategies for addressing both the social and psychological conditions that perpetuate abuse and violence across generations. The Center's goal is to provide the infrastructure and resources to enable domestic violence and mental health agencies and training programs nationwide to be able to work more effectively with individuals who are dealing with both domestic violence and mental health issues. Access DVMHPI at www.dvmhpi.org. Access NTTAC at www.dvmhpi.org/CurrentProjects.htm.

Faces and Voices of Recovery. This advocacy group is made up of individuals in long-term recovery from addiction, their families, friends and allies. Its purpose is to celebrate and honor recovery in all its diversity. The group promotes advocacy to the medical, mental health, criminal justice and other communities as well as the general public and legislators about the possibilities of recovery from addiction to alcohol and other drugs. The grass-roots organization has chapters around the country. Web site: www.facesandvoicesofrecovery.org. Address: Faces & Voices of Recovery, 1010 Vermont Ave. #708, Washington, DC 20005. Phone: (202) 737-0690. Fax: (202) 737-0695.

Faith Trust Institute is a national, multi-faith, multicultural training and education organization with global reach working to end sexual and domestic violence. Founded in 1977 by the Rev. Dr. Marie M. Fortune, Faith Trust Institute offers a wide range of services and resources, including training, consulting and educational materials. The institute provides communities and advocates with the tools and knowledge they need to address the religious and cultural issues related to abuse. The institute works with many communities, including Asian and Pacific Islander, Buddhist, Jewish, Latino/a, Muslim,

Black, Anglo, Indigenous, Protestant and Roman Catholic. Access the Faith Trust Institute at www.cpsdv.org.

National Alliance on Mental Illness (NAMI). NAMI is a nonprofit organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI's support and public education efforts are focused on educating the public about mental illness, offering resources to those in need, and insisting that mental illness become a high national priority. NAMI offers an array of peer education and training programs, initiatives and services for individuals, family members, health care providers and the general public. Access their Web site at www.nami.org.

National Center on Domestic Violence and Sexual Violence. This Web site contains a wealth of written materials and cutting-edge research on every aspect of interpersonal violence. Also on this Web site are more than two dozen versions of the famous Power & Control Wheel, which explore power and abuse dynamics for a variety of co-occurring situations ranging from substance abuse to mental health, disabilities, immigration and child welfare. Access the site at www.ncdsv.org.

National Center for Trauma-Informed Care (NCTIC). SAMHSA's National Center for Trauma-Informed Care is a technical assistance center dedicated to building awareness of trauma-informed care and promoting the implementation of trauma-informed practices in programs and services. NCTIC facilitates the adoption of trauma-informed environments in the delivery of a broad range of services including mental health, substance use, housing, vocational or employment support, domestic violence and victim assistance, and peer support. In all of these environments, NCTIC seeks to change the paradigm from one that asks, "What's wrong with you?" to one that asks, "What has happened to you?" Access their Web site at www.samhsa.gov/nctic/default.asp.

Professionals Support Group at S.T.A.R. Because hearing a traumatized person's story can revive personal traumatic experiences a service provider may have suffered in the past, it is important for providers to acknowledge and heal from their own trauma. Advocates at S.T.A.R. (Standing Together Against Rape) in Anchorage, AK, have created a support group for service providers who are trauma survivors themselves. The Professionals Group – which has weekly sessions lasting about two hours and runs for about 16 weeks at a time – has included nurses, law enforcement officers, teachers and therapists in addition to advocates. The group is co-facilitated by an advocate and a therapist. For information on this group, including suggestions for replicating such a group in your own community, contact Erin Patterson-Sexson at S.T.A.R. Phone: (907) 276-7279. Email: epatterson-sexson@staralaska.org.

Substance Abuse and Mental Health Services Administration (SAMHSA) works to improve the quality and availability of substance abuse prevention, alcohol and drug addiction treatment, and mental health services. *Substance Abuse Treatment and Domestic Violence*, part of SAMHSA's Treatment Improvement Protocol (TIP) Series, introduces drug and alcohol treatment providers to the field of domestic violence. The manual gives providers useful information on the role of substance abuse in domestic

violence — both among the men who batter and the women who are battered. Useful techniques for detecting and eliciting such information are supplied, along with ways to modify treatment to ensure victims' safety and to stop the cycle of violence in both parties' lives. Legal issues, including duty to warn and confidentiality, are discussed. Finally, the manual includes a blueprint for a more integrated system of care that would enhance treatment for both problems, along with practical suggestions for establishing linkages both between substance abuse treatment providers and domestic violence support workers and with legal, health care, criminal justice, and other relevant service agencies. Access the manual at www.ncbi.nlm.nih.gov/books/NBK14419. Access the SAMHSA web site at www.samhsa.gov.

Triple Play Connections. This non-profit organization comprised of mental health, domestic violence, sexual assault and chemical dependency providers works together to cross-train and network in local neighborhoods throughout Washington State using best practices with a focus on cultural competency. The organization has neighborhood network groups and an annual training conference. Says Karen Foley: “It’s totally self-sufficient. You don’t need funding. You just need the desire.” For information, including suggestions for replicating the organization in your own community, contact Karen Foley, (425) 259-7142, ext. 135 or 425-772-0724. Email: karenf81092@yahoo.com.

Washington State Coalition Against Domestic Violence. In the Resources section of their Web site, you will find a wealth of publications and resources created by WSCADV for advocates, survivors, and other professionals. Most are available for free or can be downloaded directly off the web site. Topics range from program management and community education to computers and technology, media, religion, and statistics and research. Of particular interest are model protocol and training tools for women with substance use issues and other disabilities. Visit the WSCADV website at www.wscadv.org.

Community Support Groups

Alcoholic Anonymous (AA) is a 12-Step community group that helps members achieve and maintain recovery from alcoholism by sharing experiences with others who have suffered similar problems. Many clients who are involved with AA find another AA member who will serve as a sponsor and provide guidance and help in times of crisis when the return to substance use becomes overwhelming. This sharing and group support approach has spawned a number of similar programs, such as Narcotics Anonymous (NA) for persons addicted to substances other than or in addition to alcohol. For more information, visit their Web site at www.aa.org.

GROW. Originally inspired by Alcoholics Anonymous, GROW is an international mental health movement with a network of member-run support groups in four different countries (the United States, Australia, New Zealand and Ireland). GROW in America is fully developed in Illinois and New Jersey, and has a small core of groups in Alaska. Web site: www.growinamerica.org. Address: P.O. Box 3667, Champaign, IL 61826. Phone: 1-888-741-GROW.

16 Steps of Discovery and Empowerment. Developed by Charlotte Kasl, Ph.D., this empowerment model brings a flexible, socially conscious approach to recovery and seeks to build self-esteem while empowering people to find their own voice. Her variation on the 12 Steps encourages people to examine beliefs, addictions and dependent behavior in the context of living in a hierarchical, patriarchal culture. Dr. Kasl also suggests the “Internalized Oppression” concept vs. the term codependency. Web site: www.charlottekasl.com. Address: Many Roads One Journey, Inc., P. O. Box 1302, Lolo, Montana 59847. Phone: 406/273-6080.

White Bison, Inc. Go to this nonprofit organization’s Web site for information about the Wellbriety Movement. Wellbriety is sobriety and wellness combined. The Movement encourages American Indian and Alaska Native communities to use culturally based healing resources to find sobriety and recovery from alcohol and drugs, and other issues including domestic violence, then go beyond survival to thriving in communities. On-line information is available at the White Bison Web site: www.whitebison.org. Contact: White Bison, Inc., 701 N. 20th St., Colorado Springs, CO 80904. Phone: 719/548-1000 or 877/871-1495. Fax: 719/548-9407.

Women For Sobriety. WFS was founded with the belief that women alcoholics require a different kind of program in recovery than male alcoholics. The WFS “New Life” program is based on a Thirteen Statement Program designed to assist a woman in addressing her alcoholism and lifestyle by encouraging her emotional and spiritual growth. On-line chat groups can be accessed from their Web site: www.womenforsobriety.org. Address: Women For Sobriety, Inc., P.O. Box 618, Quakertown, PA 18951-0618. Phone: 215-536-8026.

Trauma Websites

www.cdc.gov/nccdphp/ace ACE Study. The Centers for Disease Control and Prevention reports on the Adverse Childhood Experiences (ACE) Study – one of the largest investigations ever conducted on the links between childhood maltreatment and later-life health and well-being. As a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente’s Health Appraisal Clinic in San Diego, Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination provided detailed information about their childhood experience of abuse, neglect, and family dysfunction. Over 17,000 members chose to participate. To date, over 30 scientific articles have been published and over 100 conference and workshop presentations have been made.

www.cestudy.org The Adverse Childhood Experiences Study. The Web site’s primary focus is to share the findings of the Adverse Childhood Experiences Study, in a format readily accessible to both professionals, and the lay community. *ACE Reporter*, a free electronic quarterly publication about the findings of the Study is available on line.

www.theannainstitute.org The Anna Institute celebrates and honors the life of Anna Caroline Jennings, by using her artwork and life experience to educate others on the hidden epidemic of childhood sexual abuse, its horrific impact on individuals and society, and paths to prevention or healing. Can download articles and PowerPoint presentations of Anna's life as a child and as a mental health patient. Visitors can view an online gallery of Anna Caroline Jennings' powerful artwork, most of which was created within the walls of state mental institutions.

<http://www.phac-aspc.gc.ca/ncfv-cnivf/index-eng.php> Canadian National Clearing House On Family Violence. On behalf of the Government of Canada and its Family Violence Initiative (FVI), the Public Health Agency of Canada operates the National Clearinghouse on Family Violence (NCFV). The NCFV is Canada's resource centre for information on violence within relationships of kinship, intimacy, dependency or trust. NCFV collects, develops, and disseminates information on family violence across the country and abroad. NCFV resources and services are available free of charge in both English and French.

www.ChildTraumaAcademy.com The Child Trauma Academy is a collaborative group of individuals and organizations working to improve the lives of high-risk children through direct service, research and education. Free online courses are offered.

www.childtrauma.com The Child Trauma Institute site includes parent information, trauma measures, publications, training programs & links. The Institute provides training, consultation, information, and resources for those who work with trauma-exposed children, adolescents, and adults.

www.darkness2light.org Darkness to Light raises awareness of the prevalence and consequences of child sexual abuse by educating adults about the steps they can take to prevent, recognize and react responsibly to the reality of child sexual abuse

www.dartcenter.org Dart Center for Journalism and Trauma. The Dart Center is a global organization dedicated to improving media coverage of trauma, conflict and tragedy. The Center also addresses the consequences of such coverage for those working in journalism.

www.giftfromwithin.org A site for survivors of trauma and victimization, Gift From Within gives trauma survivors, their loved ones and supporters a credible online website that is friendly and supportive. Gift From Within believes that persons with post-traumatic stress disorder and related traumatic stress syndromes deserve the same respect and support that individuals and families suffering the impact of cancer, heart disease and stroke receive.

www.healingselfinjury.org Healing Self Injury provides information about self-inflicted violence (SIV) and a newsletter for people living with SIV, *The Cutting Edge*. Published by Ruta Mazelis and now in collaboration with the Sidran Institute, *The Cutting Edge* is in its 15th year of publication. It serves as a resource for those seeking information on

this often-misunderstood issue and includes editorial commentaries, written and artistic contributions from the readership, and reviews of various resources for those who live with SIV. Provides PDF version of the newsletter.

www.istss.org The International Society for Traumatic Stress Studies. ISTSS is an international multidisciplinary, professional membership organization that promotes advancement and exchange of knowledge about severe stress and trauma. This knowledge includes understanding the scope and consequences of traumatic exposure, preventing traumatic events and ameliorating their consequences, and advocating for the field of traumatic stress.

www.jimhopper.com Jim Hopper's site on Child Abuse Statistics, Research, and Resources. This site has several pages about child abuse – how prevalent it is, its potential effects, where to learn more and, if you're looking, how to find help for yourself or someone you care about. The site provides scholarly knowledge and resources, in language and formats accessible to any interested and motivated person – young or old, highly educated or not.

www.protect.org National Association to Protect Children. PROTECT is a national membership association founded on the belief that our first and most sacred obligation as parents and citizens is the protection of children from harm. The association is committed to building a powerful, nonpartisan force for the protection of children from abuse, exploitation and neglect through a determined single-issue focus, a meaningful mainstream agenda and the use of proven modern political strategies.

www.ncptsd.va.gov/ National Center for Posttraumatic Stress Disorder Research and education on PTSD; includes the [PILOTS Database](#), an electronic index to PTSD literature

www.nctsn.org National Child Traumatic Stress Network. The Web site's purpose is to raise the standard of care and improve access to services for traumatized children, their families and communities throughout the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

www.nsvrc.org National Sexual Violence Resource Center serves as the nation's principle information and resource center regarding all aspects of sexual violence. It provides national leadership, consultation and technical assistance by generating and facilitating the development and flow of information on sexual violence intervention and prevention strategies. The NSVRC works to address the causes and impact of sexual violence through collaboration, prevention efforts and the distribution of resources.

www.crimelibrary.com/criminal_mind/psychology/pedophiles/7.html Pedophile Characteristics, a chapter from the book *Pedophiles and Child Molesters: The Slaughter of Innocence*.

www.ncptsd.va.gov/ncmain/publications/pilots/ The Pilots Database is an electronic index to the worldwide literature on post-traumatic stress disorder and other mental-health consequences of exposure to traumatic events. It is produced by the National Center for PTSD and is available to the public on computer systems maintained by Dartmouth College. There is no charge for using the database, and no account or password is required.

www.nospank.net Project No Spank is a resource for parents, students, educators, education policymakers, healthcare providers, children's advocates, and all others who are concerned with the safety and well-being of children

www.rainn.org The Rape, Abuse & Incest National Network is the nation's largest anti-sexual assault organization. RAINN operates the National Sexual Assault Hotline and carries out programs to prevent sexual assault, help victims and ensure that rapists are brought to justice.

www.riskingconnection.com The Risking Connection Model supports transformation to trauma-informed care in all settings through training and consultation, with a focus on healing relationships. The website serves as a gateway to a Risking Connections Community providing educational opportunities and resources, and building relationship between RC creators, teachers and users.

www.sanctuaryweb.com The Sanctuary Model website fully describes a trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed. The site also includes numerous downloadable articles and makes explicit the impacts on people, communities and organizations of the larger the societal context within which they live and operate. This website is a rich source for deepening and broadening our understanding of trauma, its pervasiveness in all aspects of our lives and culture, and what is needed for healing.

www.wonderland-safe.org/safe.htm SAFE is a drop-in center in Oregon designed, owned, and operated entirely by people served by the mental health system and survivors of trauma. A beautiful publication of survivor art work "Healing In Safety: A Guide for Mental Health and Medical Professionals on How Best to Help Trauma Survivors, Written by Trauma Survivors," is available.

www.safespaceradio.com Safe Space Radio, a live forum for courageous conversations. Safe Space is a radio show about subjects that are difficult to talk about – a forum for the discussion of topics that make people feel uncomfortable. It is a space for the respectful discussion of matters that touch hearts and yet feel risky to share – subjects that deserve,

but rarely get, thoughtful consideration. Half-hour downloadable interviews with outstanding survivors and healers, conducted by Dr. Anne Hallward.

www.siari.co.uk Self-Injury and Related Issues (SIARI) – a free international Internet service of information, resources and support.

www.sidran.org Sidran Institute helps people understand, recover from and treat traumatic stress (including PTSD), dissociative disorders, and co-occurring issues such as addictions, self injury and suicide risk. Sidran develops and delivers educational programming, resources for treatment, support and self-help, trauma-informed community and professional collaboration projects, and publications about trauma and recovery.

www.stopitnow.org Stop It Now! offers adults tools they can use to prevent sexual abuse, before there's a victim to heal or an offender to punish. It provides support, information and resources that enable individuals and families to keep children safe and to create healthier communities. A network of community based Stop It Now programs reaches out to adults who are concerned about their own or others' sexualized behavior toward children.

www.traumacenter.org The Trauma Center at Justice Resource Institute helps individuals, families and communities that have been impacted by trauma and adversity to re-establish a sense of safety and predictability in the world, and provides state-of-the-art therapeutic care as they reclaim, rebuild and renew their lives. Downloadable articles by numerous authors including Bessel van der Kolk, MD, medical director and founder of the Trauma Center and internationally recognized leader in the field of psychological trauma, are available on this site.

www.trauma-pages.com David Baldwin's Trauma Information Pages focus primarily on emotional trauma and traumatic stress, including post-traumatic stress disorder and dissociation, whether following individual traumatic experience(s) or a large-scale disaster. The purpose of this award-winning site is to provide information for clinicians and researchers in the traumatic-stress field.

www.witnessjustice.org Witness Justice addresses gaps in victim services by offering direct services for survivors of violence and their allies who are experiencing difficulties. Witness Justice offers assistance and support to get answers, explanations, information, and resources for the many survivors who feel "stuck" or "lost" following violence and trauma.

www.vachss.com The Zero 5.Olaf – Official Website of Andrew Vachss. Here, you will find a searchable database of agencies and organizations which purport to serve the issues that concern us: child abuse, sexual abuse, domestic violence, animal welfare, mental health, health care, juvenile justice, human trafficking and many more, as well as other research and assistance materials.

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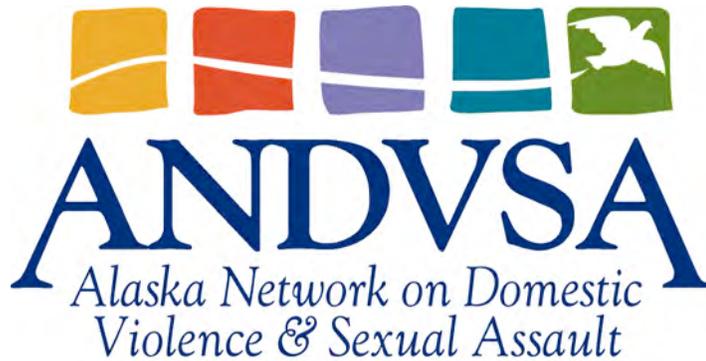
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Patti served as the Trainer for Providence Health System's Family Violence Program for five years, as an Adjunct Professor at Antioch University (teaching graduate course work in psychology) as well as undergraduate course work at Seattle Central Community College. Patti also was an instructor for Child Protective Services at CPS Academy in Seattle, WA. She has published several articles on chemical dependency and domestic violence and completed development of domestic violence curricula for the Washington State Medical Association and the Perinatal Partnership Against Domestic Violence. Patti has provided training and technical assistance on the intersection between substance use issues and violence against women in 47 states and internationally. She is the author of the Alaska Network on Domestic Violence and Sexual Assault Curriculum for Advocates and co-author, with Debi Edmund, of *Safety and Sobriety: Real Tools You Can Use*. 'Real Tools' manuals (in both English and Spanish language versions) can be found at the ANDVSA website: <http://www.andvsa.org>.



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