**Excerpt from: *Real Tools: Responding to Multi Abuse Trauma (*by Patti Bland & Debbie Edmunds;** Alaska Network on Domestic Violence and Sexual Assault

**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 whichpeople 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:

“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:

**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.”*

“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

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-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 Brodlund, 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.”

**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).