ABOUT MULTI-ABUSE TRAUMA

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, binging 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.

Because the social service system is so fragmented, cooperation between providers from a wide variety of disciplines is essential.

**References**


Slater, N. Graduate School of Psychology, Antioch University, Seattle, WA. Personal Communication with Patricia Bland, September, 1994.