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). 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.

**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.

• **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.

• **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.

- **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.

- 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.

**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.

• 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.

• 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.”

**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.”

• 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.

• Avoid overwhelming an individual with too many referrals.

• 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.

• 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.”)

• 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.

• 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.

• 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).

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

- 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
pressed 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.

Honoring 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-Díaz, 2007).

- Recognize privilege. This includes recognition of professional power (the power differential between staff and the people who come to your agency for services).

- 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).

- 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).

- Be aware of the importance of family ties in many cultures.

- Recognize that “recovery culture,” mental health “brain styles,” physical and neurodiversity (“autistic 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.

- 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).
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. Unfortunately, it also is not unusual for abusers to twist and distort spiritual or religious teachings to justify their violence.

At the same time, many people, especially those from marginalized groups, view adherence to spiritual practices as resilience against adversity (Comas-Diaz, 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.

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).

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.

• 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.

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.”

• 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 than 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:

“How 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? It’s important to celebrate “baby steps” as well as big achievements (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.

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. 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).

- 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.

- 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).

• 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.

**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.

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.

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 – it is important for us to remember there are people who may need a bit more. Be aware that the more barriers a woman has, the more support and advocacy we might need to provide (Obtinario, 2010).

References


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