TYPES OF PROVIDERS, THEIR PHILOSOPHIES AND PRIORITIES

Even when priorities and philosophies are different, this doesn’t mean advocates must compromise our own standards to work effectively with other providers. 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).

• 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 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.

• **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

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**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.”
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.

**References**


Foley, K., Triple Play Connections, Seattle, WA. Personal interview with Debi Edmund, July 2010.


King, C., University of Alaska Center for Human Development. Personal interview with Debi Edmund, November 2009.

