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.

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."

• 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:

> "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-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."

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.

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-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 ("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.

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 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:

> "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

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."

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).

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

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.

> 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.

• 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 survivior 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."

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