

MULTIPLE LAYERS OF TRAUMA

While sexual assault and domestic violence can be traumatic for anyone who experiences them, some survivors find their experience of trauma compounded in a number of significant ways – many of which “add insult to injury” and make safety and healing more complicated (Herman, 1997; Courtois & Ford, 2009; Warshaw, 2010).

Multi-abuse trauma is a term used by victims’ advocates when an individual is impacted by multiple co-occurring issues that negatively affect safety, health or well-being (Slater, 1994). Survivors of multi-abuse trauma who come to domestic violence shelters or sexual assault centers are coping with other issues besides interpersonal violence.

Examples of co-occurring issues include, but are not limited to: unresolved trauma from childhood sexual abuse, physical abuse or neglect; substance use disorders; psychiatric issues; disabilities; chronic or untreated medical conditions; growing up in a home where domestic violence or active substance abuse was present; growing up or currently living in a dangerous neighborhood; societal oppression; historical trauma or intergenerational grief; poverty; homelessness; and incarceration.

“It’s rare that I see someone who is not affected by more than one issue,” says Karen Foley, a behavioral health specialist and intensive case manager at Pacific Treatment Alternatives Safe Babies/Safe Moms program in Seattle, WA. “The majority of the people I work with are affected by multiple issues. That makes getting safe, sober and stable even more difficult” (Foley, 2010).

Multi-abuse trauma often involves both *active* forms of abuse and *coping* forms of abuse. *Active* forms of abuse include the kinds of harm that one human being does to another, while *coping* forms of abuse are the methods that victims of active abuse may use to cope with their situation.

Examples of *active abuse* include sexual assault; domestic violence; child sexual abuse, physical abuse or neglect; peer bullying; emotional or psychological abuse; and physical violence. On a societal level, examples of active abuse include sexism, racism, classism, ableism, heterosexism and other forms of prejudice and discrimination. At its most extreme, societal abuse can take the form of human trafficking, forced displacement and genocide. On both the individual and societal level, active abuse also tends to include the denial of victims’ pain and suffering, as well as blaming victims for abuses committed against them.

Examples of *coping abuse* range from substance abuse to compulsive eating, bingeing and purging, compulsive spending or gambling, self-mutilation (cutting), and suicide attempts. Coping abuses such as illicit drug use may lead to additional coping abuses such as theft or engagement in commercial sex to support an addiction. These in turn may lead to further traumatic experiences, such as increased risk of experiencing interpersonal

violence, sexually transmitted infections, homelessness or incarceration.

An individual may experience co-occurring psychiatric or other disabilities or experience a medical condition that impacts options. These issues may or may not be a direct result of trauma, but they often complicate efforts to address it.

When traumas accumulate over time, they may be associated with more severe and complex psychological reactions (Briere & Spinazzola, 2009; Brodland, 2010). Such experiences not only can produce long-term consequences themselves, but they are also risk factors for re-victimization in the future and for responding to later traumas with more extreme symptoms (Herman, 1997). Trauma may also be intensified by environmental variables, such as inadequate social support and stigma associated with certain traumas. A survivor of multi-abuse trauma shares:

“Addiction, depression and sexual assault when I was a teenager were kind of like the foundation for the several years of abuse that followed. I think it sort of conditioned me to some degree for domestic violence. Because I was addicted, I already blamed myself for the abuse I’d gotten, so it was real easy for me to continue blaming myself when I had a partner who did the same thing. I got sober, and after 10 years of domestic violence or thereabouts, I got out of that relationship, had started seeing a counselor and then was assaulted. I was with a guy I had just gone out with a couple of times, and he assaulted me pretty badly. I had a breakdown. It was the accumulation – cumulative effect – of all this trauma. I went from being a college educated professional person to having severe depression, suicidal ideation with a plan, and they put me on heavy medication.”

Does interpersonal violence cause co-occurring issues?

Both service providers and the people who seek their help are often confused about cause and effect when an individual struggles with multiple issues. To what extent does the experience of interpersonal violence contribute to mental health issues, substance use disorders, homelessness or other issues? Do these issues make a person more vulnerable to interpersonal violence?

About one in three girls and one in six boys are sexually abused before the age of 18. Both female and male survivors have been found to suffer long-term effects from such abuse, including more suicide attempts, alcohol and drug problems, psychiatric issues and learning disabilities – problems which often persist into adulthood (ICASA, 2001).

Depression, post-traumatic stress disorder, anxiety and panic disorder are common among people seeking services from domestic violence shelters (Warshaw et. al., 2003). However, some experts believe that many behaviors and responses seen as “symptoms” by service providers are directly related to traumatic experiences that can cause mental health, substance abuse and physical health concerns (NCTIC, n.d.). Shirley Moses, Shelter Manager at Alaska Native Women’s Coalition in Fairbanks, AK, believes survivors of sexual assault or domestic violence are often misdiagnosed as having mental

health or psychiatric disorders, because the symptoms of trauma can masquerade as mental illness. She says mental health problems can also be “situational,” brought on by domestic violence or sexual assault, and other traumas:

“You might see someone who is losing her kids because she is sleeping half the day or she’s not able to cope anymore. She’s closing down, and they are thinking she’s mentally ill or she’s not trying to take care of herself or she’s not able to provide. And they don’t look at, why is she doing this?” (Moses, 2010)

The Women’s Action Alliance’s experience with a domestic violence shelter program over a fifteen-month period indicated 60-75% of the women seeking shelter services had developed problems with their original coping mechanism, alcohol and drugs (Roth, 1991). The Minnesota Coalition for Battered Women (1992) notes abused women may use alcohol or drugs for a variety of reasons, including coercion by an abusive partner, substance dependence, cultural oppression, over-prescription of psychotropic medication or, for women recently leaving a battering relationship, a new sense of freedom.

A survivor of multi-abuse trauma shares how she often blamed herself for violence:

“Because I was addicted, I already blamed myself for the sexual assault that happened when I was in my teens, so it was real easy for me to continue blaming myself when I had a partner who abused me as well.”

Domestic violence and poverty also are interwoven, says Jill Davies in a policy and practice paper *Policy Blueprint on Domestic Violence and Poverty*:

“Efforts to escape violence can have devastating economic impacts. Leaving a relationship might mean a woman will lose her job, housing, health care, child care, or access to the partner’s income. Often, criminal and civil legal remedies are necessary to safely leave a relationship. Criminal remedies typically have no monetary cost to the victim, but may take time away from work or job training, sometimes resulting in lost wages or loss of employment. The pursuit of civil legal strategies, such as divorce or custody actions, often drains family financial resources. Unable to afford litigation, some battered women concede financial and property demands in order to settle the case, further undermining their families’ security” (Davies, n.d.).

Domestic and sexual violence can push victims into a cycle of poverty. Experiencing interpersonal violence can lead to job loss, poor health, and homelessness. It is estimated that victims of intimate partner violence collectively lose almost 8 million days of paid work each year because of the violence perpetrated against them by current or former partners or dates (Cawthorne, 2008).

TRAUMA AND CO-OCCURRING ISSUES

Trauma is often the common thread or common denominator running through a variety of co-occurring issues, ranging from mental health concerns to substance abuse, poverty, exploitation by the sex industry, homelessness and incarceration. A look at some statistics provides examples of how trauma is involved in many of the current problems faced by people seeking help from social service agencies, especially people who are struggling with multiple issues simultaneously:

- **Substance abuse.** Preliminary data from a National Institute on Drug Abuse study noted 90 percent of women in drug treatment had experienced domestic violence from a partner during their lifetime (Miller, 1994). As many as 74 percent of women in substance abuse treatment have experienced sexual abuse (Kubbs, 2000).
- **Mental health.** As many as 90 percent of people who have severe psychiatric symptoms are survivors of at least one incident of trauma during their lifetimes (Akers et. al., 2007). Studies have found that up to 53 percent of people who seek services from public mental health centers report childhood sexual or physical abuse (Huckshorn, 2004). In one study, of the 90 percent of people receiving public mental health services who had been exposed to trauma, most had multiple experiences of trauma (Huckshorn, 2004).
- **Disabilities.** A person with a disability – regardless of age, socioeconomic status, race, ethnicity or sexual orientation – is twice as likely to be a victim of abuse than a person without a disability (Wayne State University, 2002). Among adults with developmental disabilities, as many as 83 percent of women and 32 percent of men have been victims of sexual assault (ICASA, 2001). In addition to abuse by family members or intimate partners, people with disabilities are at risk for abuse by attendants or health care providers. They are also more likely to experience a longer duration of abuse than people without disabilities (Young et. al, 1997). Street crime is a more serious problem as well. Studies have shown that people with disabilities

The Adverse Childhood Experiences (ACE) Study provides data linking adverse childhood experiences such as sexual abuse and witnessing domestic violence as factors contributing to psychiatric illness, substance abuse and other health problems (Felitti et al, 1998). However, the extent to which these and other issues make a person more vulnerable to interpersonal violence requires more study by feminist researchers.

It is important to emphasize that people who experience interpersonal violence neither “ask for” nor deserve violence or abuse – no matter what else is going on. The most important message you can give a person whose experience includes multiple abuse issues is, “This is NOT your fault.” This message is especially important if individuals

have a four to ten times higher risk of becoming crime victims than persons without disabilities (Wayne State University, 2002).

- **Poverty.** Studies show that over 50 percent of women receiving public assistance report having experienced physical abuse at some point in their adult lives, and most of these women also report a history of physical and/or sexual abuse in childhood (Lyons, 2000).

- **Homelessness.** One study found that 92 percent of homeless women had experienced severe physical or sexual abuse at some point in their lives. Of all homeless women and children, 60 percent had been abused by age 12, and 63 percent have been victims of intimate partner violence as adults. Among cities surveyed by the U.S. Conference of Mayors in 2003, 44 percent identified domestic violence as a primary cause of homelessness (National Network to End Domestic Violence, 2004).

- **Sex trafficking.** Although not all sexually abused children are recruited into commercial sex, the majority of individuals involved in the commercial sex industry have a history of sexual abuse as children, usually by several people (Farley, 2003). One study found that 66 percent of people involved in commercial sex were victims of child sexual abuse. Women sexually abused as children are four times more likely than women who haven't been abused to work in the commercial sex industry, while men sexually abused as children are eight times more likely to work in the commercial sex industry (ICASA, 2001).

- **Incarceration.** Incarcerated people have a history of trauma at much higher rates than the general population. The rate of physical or sexual abuse or violence experienced by incarcerated women, either within their families or by intimate partners, is quite high – estimates vary from 44 percent to 80 percent – compared to that reported by women in the general population – a 30 percent lifetime occurrence (O'Brien, 2002). In a study of inmates at a Midwestern state prison, 22 percent of male respondents said they had been forced to have sexual contact against their will at least once while incarcerated (ICASA, 2001).

were under the influence of alcohol or drugs, were experiencing psychiatric symptoms, or were coping with other co-occurring issues at the time an abuser took advantage of and hurt them.

“There are confusing mixed messages when the people we serve are not ‘perfect victims,’ and they fight back, and they also – in the grips of their addictions – commit crimes,” says Seattle behavioral health specialist Karen Foley. “And then, at the same time they’re dealing with sexist issues, they’re dealing with poverty. They are oppressed in society. It’s just so intertwined.”

Along with a non-judgmental, non-blaming message, it is also important to offer a message of hope. While we can acknowledge that co-occurring issues may make it harder for people to get safe, sober *or* whole, people experiencing multiple abuse issues must be reminded that they are in control of their own decisions. They have options and advocates to support their safety, autonomy and justice. We can listen, believe them, validate the choices they make, and help them feel connected.

Another layer of trauma: Societal abuse and oppression

An additional layer of trauma may further complicate the situation for people who are survivors of multi-abuse trauma. In addition to the stigma and barriers surrounding issues such as a substance use disorder, psychiatric illness, and various forms of trauma, they may be facing societal abuse.

Societal abuse refers to the disadvantages that a group experiences as a result of unjust social structures (Benbow, 2009). An example is discrimination and oppression based on misperceptions about race or ethnicity, age, socioeconomic status, disabilities, sexual orientation and immigration status. Manifestations may range from lack of accommodations to inadequate funding for social services, lack of access to health care, inadequate social policies to protect against abuses, and negative images and stereotypes in the media (Schwartz-Kenney et. al, 2001).

Marginalized groups are disproportionately affected by poverty, homelessness and incarceration – not because they commit more crimes or have greater rates of pathology, but because discrimination often keeps them from getting the same benefits enjoyed by members of the dominant culture (Davies, n.d.; Cawthorne, 2008; HUD, 2007).

Discrimination and other forms of societal abuse are traumatic to the people who are targeted and can, in themselves, result in post-traumatic stress. Some experts speak of *minority stress* (Green, 2007) and *postcolonization stress disorder* (Comas-Diaz, 2007), which result from struggling with discrimination and oppression, as well as the imposition of mainstream culture as dominant and superior. Psychological effects include depression, shame, rage and posttraumatic stress disorder.

Naomi Michalsen, Executive Director of Women In Safe Homes (WISH), in Ketchikan, AK, discusses the anger:

“A lot of my Native brothers and sisters are angry. They’ve realized a little bit about what happened. In order to begin healing, I believe we need to come to a point where we try to understand, or acknowledge, some of the things that happened and talk about all those things we know – and be believed. In a way, part of that has to come from learning about our culture again and the values” (Michalsen, 2007).

Internalized oppression occurs when people absorb society’s attitudes toward their particular group and direct those negative attitudes toward themselves (Green, 2007). One can think of internalized oppression as the internalized police officer that keeps

individuals in their socially prescribed place (Roy, 2007). Sometimes the internalized oppression can take a tragic turn, according to Shirley Moses, Shelter Manager at the Alaska Native Women’s Coalition in Fairbanks, AK:

“One thing that has come full-blown now, and that the state has recognized, is young men or young women committing suicide tied to sexual abuse, or tied to violence in the home. They are looking at the bigger picture, saying there’s underlying reasons that need to be addressed so we can help villages and our people get healthier – and we can address suicide as something tied to domestic violence, child maltreatment and the breakdown of the families” (Moses, 2010).

Trauma can also be passed from one generation to the next. Experts use the term *intergenerational grief* to refer to grief passed on from the generation experiencing the trauma to their children even though they may not be aware of or have direct experience of the actual traumatic event. *Historical trauma* refers to cumulative trauma that occurs in history to a specific group of people, causing emotional and mental wounding both during their lives and the generations that follow (AIFACS, n.d.). Shirley Moses relates:

“Historical trauma is never addressed. And there are layers. We’ve had women that are 70 and 75 years old report being traumatized, maybe for the first time, because we were doing DV 101, and talking about sexual abuse. And that historical trauma piece, they were reporting in our training for the first time that they had been sexually abused as children. So you go back to pre-contact or early contact, when we had traders or outside people coming into Alaska. There was that life change where you had clashes between the Native culture and the non-native cultures, and the disconnect. The leadership was different. A lot of places don’t have the traditional Native leaders. The elders are not utilized as experts as much. It’s changing, but there’s still a long way to go. And the reconnect of teaching our children and our youth and our young parents to honor their culture, to honor their ways, to honor their ancestors, I see that changing, but it’s so slow. And a lot of our young people don’t even recognize a way they can regain the old social norms. A lot of them have struggled with the cultural beliefs, and the leadership. I think that’s starting to shift, because we are talking about it more, the way that disconnect has hurt our villages. But I think that intergenerational grief, it’s loss of culture. Lots of our young people don’t speak the native language” (Moses, 2010).

Barriers to service for people seeking help

Very few programs provide comprehensive services for people impacted by multiple issues. Survivors of multi-abuse trauma are often invisible when in our programs, or are perceived as disruptive when co-occurring issues such as substance use or psychiatric symptoms become evident or unmanageable. Many times people with co-occurring or multiple abuse issues are missing from community programs altogether.

Victims of domestic violence and survivors of sexual assault who struggle with multi-abuse trauma often need our services the most. Yet, having multiple issues makes it

harder for a survivor to access appropriate services in a variety of ways:

- *Confusion over how to access services.* One study found that people with mental health concerns are often confused over how to access and use available services. The more severe the psychiatric disability, the greater the level of confusion (Rosenheck & Lam, 1997). This can be an issue for people who have other co-occurring issues as well.
- *Lack of self-advocacy skills.* Not knowing how to advocate for oneself can pose a significant problem for people coping with multiple issues (Obtinario, 2010). A survivor shares:

“I didn’t go to the doctor until several weeks after I was assaulted. And when I told them what had happened to me, they just sort of patted me on the head and said, ‘There, there.’ There weren’t any marks at that point. So it was like, ‘Let’s give her some Librium for a few days to calm her down. And give her some antidepressants.’ Five months later we found out that my neck had been broken. Because I did not advocate strongly for myself, and because I was docile and withdrawn, they weren’t very aggressive about checking out my health. That could have been very dangerous for me. So I think it’s very important for medical providers, when they learn that somebody has had domestic violence, to do a very thorough examination. Because I was incapable of being assertive for myself at that time, I didn’t get the medical care I really needed.”

- *Fragmented services.* For people who live in urban areas with many kinds of services, the system may be fragmented and they cannot receive everything they need from one provider (Akers et. al., 2007). An individual may need to go to one provider to access domestic violence services, another provider to obtain treatment for a substance use disorder, still another provider for mental health services, and several more providers to receive public assistance.
- *Hard-to-access or nonexistent services.* If someone lives in a rural or remote area, these same services may be extremely hard to access, or may not be available at all. Shirley Moses of the Alaska Native Women’s Coalition points out the challenges faced by women who live in remote communities:

“There aren’t the services out there, or it is cost prohibitive. Most airline fares are \$200-\$300 per person one way, and most of the women have two or three children at least. Even if you have money to fly them out, there might be a storm like we had last week where you had everything close down because it was raining for four days. If it freezes you have planes sliding off the runway. Then there are snowstorms. She could be from a village that is out of the region, and if she is in a domestic violence situation, her family might be 500 miles away in a different part of the state where you have to come to Fairbanks, go to Anchorage, go to Bethel, and then get to one of the hub villages” (Moses, 2010).

- *Lack of family-focused services.* Services for parents and children may be fragmented. Funding streams, and program eligibility requirements for mental health centers and other

services may limit participation to eligible adults or children, but not both. Services for adults and children may be provided in different locations. Programs or treatment settings may not allow adults to bring their children with them – e.g., emergency shelters or residential programs (Nicholson et al., 2001).

- *Conflicting expectations.* Each provider may have different rules, some of which conflict. For example, a substance abuse treatment program may require attendance at a group counseling session that extends until after the curfew at the domestic violence shelter where an individual is staying. A public assistance program may require applicants to be seeking employment, while some “half-way houses” may require the same individual to delay seeking employment until after completing other goals identified in treatment plans. Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle, offered the following example of how conflicting expectations can affect a person who must seek services from more than one agency:

“I had someone who was sitting at an inpatient treatment center, and her TANF money was sanctioned. When I took her to the local community service office to talk with her TANF worker, the TANF worker said they were available at a certain day, at a certain hour to discuss this and that’s it. So this individual is sitting in an inpatient treatment center where they are mandated, if they want to keep their children, to attend every treatment hour offered. They cannot miss a treatment hour. There are only certain hours they can take care of business. If she wants to keep her child, she must attend treatment and if she wants to stay in treatment she has to follow these rules. At the same time, in order to stay in treatment, she needs to pay for it, and her child is charged \$300 a month to be in treatment with her. If her money continues to be sanctioned, she doesn’t have the money to pay for treatment. So the inflexibility of the system in being able to work with her made it impossible for her to not continue getting sanctioned” (Foley, 2010).

A survivor of multi-abuse trauma shares her experience of not being taken seriously:

“I didn’t go to the doctor until several weeks after I was assaulted. When I told them what had happened to me, they just sort of patted me on the head ... Five months later we found out that my neck had been broken.”

- *Inability to afford services.* People may be unable to afford some mental health or substance abuse treatment services if they do not have insurance, or if they have insurance that doesn’t cover services adequately (a problem for an increasing number of middle-class people as well as people living in poverty). Even if services such as domestic violence advocacy, sexual assault counseling or mental health services are offered free of charge by advocates or other providers, some people may not be able to

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SAFETY ISSUES: MULTI-ABUSE TRAUMA

Co-occurring issues such as a substance use disorder, mental health concerns, disability, societal oppression or poverty can make it harder to get safe from interpersonal violence or abuse. At the same time, inability to get safe or heal from interpersonal violence makes it harder to address other issues.

Co-occurring issues make it harder for victims of interpersonal violence to get safe in a variety of ways:

- The co-occurrence of domestic violence and substance use (or misuse) is well documented and associated with increased lethality rates and greater severity of injuries for people impacted by these public health risks. Severity of injuries and lethality rates climb for individuals who experience both substance dependence and battering (Dutton, 1992). Acute and chronic effects of alcohol and other drug use may prevent a victim from accurately assessing the level of danger posed by a perpetrator (Bland, 2007). Alcohol and other drug use may be encouraged or forced by an abusive partner as a mechanism of control, and abstinence and recovery efforts may be sabotaged (IDHS, 2000). For example, a domestic violence/sexual assault victim receiving methadone on a daily basis could easily be stalked.
- Psychiatric symptoms can have an impact on safety (Bland, 2007). Accurate assessment of danger may be impacted by thought disorder symptoms. Traumatic brain injury or psychiatric symptoms can impair judgment and thought processes (including memory), making safety planning more difficult. There may be reluctance on the part of the individuals with psychiatric symptoms to seek assistance stemming from fear of being labeled, institutionalized or medicated.
- Both mental and physical problems, whether temporary or more long-term, can diminish some people's ability to work, participate in job training or education programs, or comply with government benefit requirements (Davies, n.d.). All of these factors can make it harder to escape violence.
- Some people with disabilities depend on caregivers – either a spouse, other family members, or paid assistants – for essential personal services. This can create a barrier to terminating an abusive situation because to do so would leave the victim without essential support services (Wayne State University, 2002).
- If someone has a developmental disability, cognitive and processing delays may interfere with the ability to understand what is happening in abusive situations. This problem is compounded by the fact that people with developmental disabilities are often not provided with general sex education, so they may not recognize what is happening to them in a sexually abusive situation (Charlton, et. al., 2003).

- Being a member of an oppressed group can pose safety issues. For example, some people of color may be reluctant to report violence because of their community's negative experiences with police, while fear of exposure – or being “outed” – may prevent lesbian, gay, bisexual or transgendered people from seeking help to end violence (IDHS, 2000).
- A person experiencing poverty may find it much more difficult to implement a safety plan. People must be able to financially support themselves and/or their children after leaving an abusive partner. Most programs that provide housing, temporary cash assistance, child care, and free legal representation have limited funding or offer only short-term help, and many have extensive waiting lists. As a result, some low-income individuals simply are without the income, government support, or access to services necessary to fully implement a safety plan (Davies, n.d.).
- Fear of legal sanctions can interfere with safety as well. People victimized by violence may be reluctant to contact police or seek other assistance for fear of prosecution, investigation by a child welfare agency, or deportation – especially if they disclose illegal immigration status, use illicit drugs or have engaged in illegal activities such as theft or commercial sex to support an addiction (IDHS, 2000).
- Trafficking victims and people being exploited by the sex industry generally lack access to money, “systems” or those who could help them to escape. Trafficked persons may also be from outside U.S. borders, which may leave them in fear of deportation (Song & Thompson, 2005).

Inability to get safe or heal from interpersonal violence also makes it harder to address co-occurring issues:

- For people in substance abuse treatment, failure to address current or past victimization can interfere with treatment effectiveness and can lead to relapse (SAMHSA, 1997). Someone in recovery for a longer period of time also may find the stress of securing safety leads to relapse.
- Abusers may try to prevent victims from keeping appointments for mental health counseling, obtaining public assistance, or seeking other services. Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at S.T.A.R. (Standing Together Against Rape) in Anchorage, AK, says:

“I think a lot of the people we see have partners that are keeping them intoxicated or encouraging them to over-medicate, not relaying our messages to the victims when we are calling them, not wanting to bring them into the office, or allowing them to come and then calling them five times on their cell phone as we are sitting together in a one-on-one session” (Patterson-Sexson, 2010).

afford babysitting, accessible transportation, or (for people with disabilities) medical equipment or a personal attendant (Leal-Covey, 2011). A fragmented system makes services harder to access, particularly for someone who lacks accessible transportation.

- *Cultural barriers.* People from marginalized groups often find it harder to access social services – especially if most of the staff represent the dominant culture, or services are based on the values and customs and beliefs of the dominant group (Duran, 2006). A social service system dominated by Western ways of approaching issues may feel intimidating. There may be language barriers, or customs that feel alien to the individual. Even the food served at a shelter or residential facility may be alien. Erin Patterson-Sexson at S.T.A.R. in Anchorage offers an example:

“In addition to a large Native Alaskan population, we have a lot of Hmong, Pacific Islanders, women from all parts of Asia, and most of the advocates here are Caucasian. Many victims are afraid of law enforcement, and see any kind of helping service as a betrayal of their family, a betrayal of their culture. So they don’t seek the services or they don’t continue with us beyond the crisis intervention phase.”

- *Lack of accessibility.* According to the National Coalition Against Domestic Violence and the National Coalition Against Sexual Assault, inaccessibility in shelters is a serious problem for people with disabilities. These programs generally operate on very thin budgets and covering the cost of accessibility modifications and services is a substantial challenge. One study found that only about a third of providers offered safety plan information modified for use by people with disabilities, or disability awareness training for program staff, and personal care attendant services were available in only 6 percent of abuse programs (Nosek et. al, 1997).

- *Housing discrimination.* Individuals and families across the country are being discriminated against, denied access to, and even evicted from public, subsidized, and private housing because of their status as victims of domestic violence or the abuse perpetrated against them. Landlords frequently turn away individuals who have protection orders or other indications of domestic violence (National Network to End Domestic Violence, 2004). This means a person seeking services may need emergency shelter for a longer period.

- *Restrictions on length of shelter stays.* The average stay at an emergency shelter is 60 days, while the average length of time it takes a homeless family to secure housing is six to ten months. Many domestic violence shelters are unable to house families longer than 30 days to allow space for individuals in immediate danger. There are not enough federal housing rent vouchers available to accommodate the number of people in need. Some people remain on a waiting list for years, while some lists are closed (National Network to End Domestic Violence, 2004).

Challenges for providers

Co-occurring issues create challenges for shelter staff and other service providers:

- *Behavioral challenges.* Some behavior may pose challenges for staff (IDHS, 2000). For example, a person who suffers from depression may have difficulty achieving goals or performing tasks in a timely manner. A person with substance use disorder may repeatedly violate a shelter’s curfew or come back to the shelter intoxicated. A person with psychiatric symptoms may behave in ways perceived as disruptive to staff and other residents. Behaviors stemming from trauma, self-harming actions such as cutting, or suicidal threats may make group living challenging. Psychiatric issues, developmental disabilities or language barriers may make it harder to understand or follow certain rules.

- *Lack of cross-training.* Advocates and other providers often lack training on issues other than the one for which their own agency provides services (Akers et al., 2007). When this is the case, they will have valid ethical concerns about working beyond their competence level (SAMHSA, 1997).

- *The complexity of the individual’s problems.* Services for people with multiple issues need to be intensive and personalized, and providers must focus on both short-term and long-term needs. This is not to say that specialized, single-focus agencies such as domestic violence shelters, substance abuse treatment programs or mental health centers don’t work. They do, for a lot of people. But a survivor of multi-abuse trauma usually needs more than what any one agency can provide, no matter how competent we are.

- *Funding barriers.* Social service agencies depend on continuous, reliable funding to remain in existence. Whether the money comes from government sources or the private sector, many funders want to see “numbers” and clear-cut “evidence-based” results. This system tends to benefit agencies who can help large numbers of people resolve their issues, once and for all, in a short period of time. Helping a survivor of complex trauma resolve multiple issues may require months or even years of intensive services (Courtois, Ford & Cloitre, 2009), and results may be difficult to measure short-term. A provider’s particular service may be only the first step for this person.

- *Personnel shortages.* Limited budgets, geography and weather often mean staff and resources are stretched to the limit. Shirley Moses of the Alaska Native Women’s Coalition discusses the situation in rural and remote areas of Alaska, where a quick response can mean life or death. Bad weather, long distances and a limited number of available law enforcement personnel might slow a response to sexual assault or domestic violence in a remote or rural community for hours or days at a time:

“We have four troopers for, I think, 20 or 30 villages here in the interior. Four full-time troopers, and they have to sleep sometime. And they have limited access to

A survivor of multi-abuse trauma shares:

“As someone who has survived domestic violence, there’s an antenna on my head that can detect who is sincere and who isn’t. ... I tested many, many people to see if they were going to be loyal and confidential.”

airplanes or even commercial flights to fly in, especially in bad weather. Lack of resources – money is always a problem. It costs money to pay for law enforcement and the state has a limited budget and a lot of territory to cover” (Moses, 2010).

- *The desire for success stories.* Both funding organizations and the public tend to want success stories, in which the success is evident in a form that is measurable. This can lead to the temptation for service providers to engage in “cherry-picking.” Because of the desire to show funders that one’s program is successful, a provider may either consciously or subconsciously pick participants deemed to have the best chance of succeeding, while screening out those who might “fail” or those who would take too long to succeed. This can work against survivors of multi-abuse trauma who are dealing with multiple issues that take longer to resolve.
- *Manipulation by abusers.* Naive, inexperienced or inadequately trained staff may fail to fully understand tactics batterers use or underestimate their willingness to go to whatever lengths are necessary to maintain control of those they perceive as belonging to them. This serious mistake can leave providers vulnerable to manipulation by batterers and subject to collusion. Failure to identify risk undermines treatment efficacy and victim safety. It may also lead to increased liability.
- *Barriers to cooperation between providers.* Cooperation between providers from a variety of disciplines is needed in order to address the multiple issues involved in multi-abuse trauma. Developing linkages or collaborating across these sectors is fraught with problems, and many barriers to cooperation exist. These include differing priorities, funding restrictions, lack of trust between providers with differing philosophies, and lack of cross-training in issues other than the issue addressed by a particular agency.

Karen Foley is the founder of Triple Play Connections, a Seattle-based non-profit organization comprised of mental health, domestic violence, sexual assault and chemical dependency providers working together to cross-train and network in local neighborhoods throughout Washington State. She says:

“I think the biggest barrier [to cooperation between providers] is a lack of understanding of the other issues. Each of us has our own priorities as to what is the most important thing to work on and how to go about that. And we’re very strong in our knowledge base. But when you have intersecting issues, you can do more damage by believing your way is the only way, and by not talking to one another as providers” (Foley, 2010).

Consequences when co-occurring issues are not addressed

Advocates and other providers agree it is hard to meet higher-level needs such as emotional healing when basic needs such as food and housing are not met. Erin Patterson-Sexson at S.T.A.R. in Anchorage says:

“It’s like Maslow’s hierarchy of needs. You can’t deal with those intellectual and emotional needs until the basic needs are met. We are not getting anywhere if we are trying to address emotional needs when her rent is overdue and her heat has been turned off” (Patterson-Sexson, 2010).

When a multi-abuse trauma survivor’s issues are not adequately addressed, serious consequences may follow:

- Physical and medical problems can develop. “I’m a firm believer that when you’re in so much hurt and so much pain, you cannot go beyond a certain volume,” says Daisy Barrera, an advocate from Bethel, AK. “Your body’s going to break down” (Barrera, 2009).
- Ability to maintain employment, housing, health insurance or child custody may be threatened by current or past substance use disorders or mental health problems (Akers et. al., 2007). Societal attitudes tend to view substance use disorders and psychiatric symptoms as moral failings rather than as health problems. This can lead to isolation and shame, which may be compounded when domestic violence and/or sexual assault co-occur with these other issues.
- People with multiple issues may believe they have no other choice but to return to an abusive situation again and again, because they have nowhere else to go where they feel welcome or safe.
- Individuals may bounce in and out of the system, moving from one social service agency to another, resulting in a revolving door syndrome in which underlying problems and issues are never adequately addressed (Akers et. al., 2007).
- Survivors may develop coping mechanisms such as substance abuse or eating disorders to deal with continuing trauma, or to self-medicate post-traumatic stress disorder stemming from interpersonal violence or abuse (Bland, 2007).
- Inability to access appropriate services makes it more likely that trauma of all kinds will continue, resulting in even more trauma. “The traumas just keep compounding and compounding,” says Gene Brodland, a licensed clinical social worker at the Southern Illinois University School of Medicine (Brodland, 2010).

A survivor of multi-abuse trauma shares:

“I thought simply stepping back and not saying anything would help me. It didn’t. My body shut down to the point where I almost died, because I kept everything to myself. It turned medical, with pneumonia, which resulted in asthma, because I held that garbage. I carried that around in me without ever revealing it to somebody.”

- Ultimately, an individual may end up on the streets, homeless, or even incarcerated. A survivor shares how the cumulative effect of domestic violence on top of her history of trauma affected her:

“How did it affect me? In every way possible. It interfered with my sobriety. I ended up relapsing after many years of being clean and sober. I ended up losing my career. I lost the place where I lived. I became homeless. I was physically injured with permanent effects. My ability to form relationships with people suffered – my gosh, I already had trust issues. I still do, and I’m 55 years old.”

Meanwhile, abusers are not held accountable for their actions and benefit from lack of services for victims with multiple abuse issues. Abusers also benefit from the stigma and discrimination survivors with multiple abuse issues face. This stigma and discrimination is often fostered by abusers who use substances to induce debility and better control their partners (Hampton, 2005). Abusers may encourage, trick or force a targeted individual to use substances to facilitate rape, to undermine their victim’s credibility, their access to their children and their access to support of any kind.

Yet another layer: Trauma from the system

Finally, people with multiple issues may experience trauma from the very social service system that was designed to help them. The inability to access appropriate services creates its own stress. The system itself thus adds to, rather than alleviates, their problems:

- When social service fragmentation leads to people getting 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.
- Each provider may have their own theory about what causes human problems. If people who seek help are pressured to adopt these conflicting theories, they may become confused and angry.
- As people with multiple issues revolve around the system, they may acquire multiple labels. They then become defined by their labels rather than viewed as human beings, and are thus dehumanized by providers in the system as well as by their abuser.
- The experience of being labeled, dehumanized, and passed around the system re-traumatizes people with multiple issues, making it even more difficult for them to address their issues.
- For many survivors of trauma who have disabilities or psychiatric issues, 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.).

- Intimate partner violence, substance abuse or dependence, and mental illness all may result in a person becoming homeless (NCH, 2006). Psychiatric symptoms and homelessness have become criminalized, and jails and prisons have become a dumping ground for warehousing people with mental health issues and people who are homeless (Treatment Advocacy Center, 2007).
- The tools a person uses to cope with trauma – such as substance abuse, commercial sex or running away from home (if under 18 years old) – are often pathologized or criminalized (Gilfus, 2002). An example of this would be an adolescent girl who runs away from home to escape incest and is forced into commercial sex or is incarcerated in a juvenile detention facility.
- The physical and psychological violence of commercial sex or sex trafficking, the constant verbal humiliation, the social indignity and contempt, can result in personality changes that have been described as complex posttraumatic stress disorder, particularly if the individual was forced into the sex trade (Herman 1997).
- People who become homeless find that homelessness itself is a traumatic experience. Individuals and families who are homeless are under constant stress, often unsure of where they will sleep tonight or where they will get their next meal (Barrow et. al., 2009).
- If people with multiple issues end up homeless or incarcerated, they may then suffer posttraumatic stress disorder from the homeless or incarceration experience (Wong, 2007). A person who has been incarcerated – especially if incarcerated more than once – may suffer from *post-incarceration syndrome*, a form of post-traumatic stress disorder stemming from the incarceration experience itself (Gorski, 2001).
- People experiencing multiple forms of abuse may actively hide what has happened to them, as well as their methods of coping. Thus, their experiences of multiple forms of abuse become invisible.

Policies and practices may deny or limit services for individuals who have been exploited by the sex industry or incarcerated, or who experience chronic homelessness. Shelter and other services may also be denied to people who currently experience suicidal ideation, use substances or have some other issue perceived as problematic.

This response silences those who seek services, drives these issues underground and rewards those who can cover up best. The secrecy and invisibility lead to more juggling, more trauma, more shame and greater risk for future harm as survivors increasingly fear revealing who they really are and remain invisible, silent and afraid to ask for what they really need beyond what is most pressing.

As one survivor shared, “When someone has a gun to your head, you are not going to tell the advocate on duty you just shot up. You’ll say anything to get in the door.” Survivors may want to please advocates rather than disappoint them. They may fear being judged, reported to authorities, kicked out, or labeled.

Additionally, some advocates may be afraid to ask survivors about indicators of substance use or other concerns, due to fear. This may be fear the advocate won't know what to do, fear of how the individual seeking services will react, or fear the advocate will have to ask the individual to leave.

The resultant aura of invisibility maintains an uneasy status quo that can be shattered at any moment. Should a problem erupt, its exposure has the capacity to overwhelm a survivor's ability to function – let alone experience safety, autonomy and justice. A punitive response could also lead to increased trauma, isolation and shame.

Behavioral health specialist Karen Foley of Triple Play Connections believes social service providers must cooperate and work closely together in order to avoid further traumatizing victims of violence who have multiple issues:

“Probably the biggest example that demonstrates this is when providers say, ‘We’re not equipped to deal with that issue.’ While we certainly don’t want providers to practice outside their area of expertise, we absolutely need to deal with it, and know our local providers and refer to the experts, rather than denying access to services” (Foley, 2010).

Providers across disciplines have begun to agree that we all must broaden our focus to at least consider what other issues people may be facing when they come to us for services. Gene Brodland, of the Southern Illinois University School of Medicine, says:

“I think unless you have a very broad definition of who you are and what kinds of things you address, you become extremely limited in terms of what you can do to work with someone. When you only throw a drug at them, or you only throw alcohol treatment at them, or you only throw some other kind of service at them, and you don’t consider the other issues, you’re really letting them down. You’re going to miss the very essence of caring for human beings” (Brodland, 2010).