Substance Use/Abuse in the Context of Domestic Violence, Sexual Assault, and Trauma

By Patricia J. Bland, M.A. CDP & Debi Edmund, LPC CADC

Content Contributions: Cathy Cave, Niki Miller, Erin Tinnon
Design: Juliana Pino, Erin Tinnon

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Dedication

In Memoriam

We dedicate this manual to all those who tirelessly work for social change on behalf of others to bridge the gap between what people need and what programs and systems are willing to provide.

“We will remember you…”

Fierce Advocates, Counselors, and Nurse:

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**Editor:** Erin Tinnon, MSW, NCDVTMH Consultant, Ann Arbor, MI

**Layout and Design:** Juliana Pino, Public Awareness Associate & Technology Specialist, NCDVTMH, Ann Arbor, MI

**Administrative Support:** Kathleen Pabian, NCDVTMH, Chicago, IL

**Content and Curricula Development:**

Mary Lee Berg, RN BSN MS, Assistant Professor, Nursing Department, Onondaga County Community College, Syracuse, NY

Susan Blumenfeld, MSW LCSW, Child Trauma Training Director, NCDVTMH, Chicago, IL

Cathy Cave, Consultant, Inspired Vision, LLC, Delmar, NY

Jen Curley MSS MLSP, Project Manager, NCDVTMH, Chicago, IL

Eleanor Lyon, PhD, Consultant, Coeur d’Alene, ID

Kelly Miller, JD, Idaho Coalition Against Sexual & Domestic Violence (ICASDV), Boise, ID

Niki Miller M.S. CPS, Consultant, NH

Terri Pease, PhD, Consultant, Portland, ME

Heather Phillips, MA, Research Manager, NCDVTMH, Chicago, IL

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“Together we can do, what we could never do alone”

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Trainer’s Guide
TRAINER’S GUIDE

Substance Use/Abuse in the Context of Domestic Violence, Sexual Assault, and Trauma

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This project was supported by Grant No. 2011-TA-AX-K128 awarded by the Office on Violence Against Women and the U.S. Department of Justice Family Violence Prevention and Service Program Administration on Children Youth and Families Administration for Children and Families, U.S. Department of Health and Human Services. The opinions, findings, conclusions and recommendations expressed in this training module are those of the authors and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women or the U.S. Department of Health and Human Services.

Overview of Curriculum

This training module is designed for advocates and their community partners to provide trauma-informed training on substance use and abuse in the context of domestic violence and sexual assault. The module is designed to be flexible and offers a variety of options.

Training Goals

1. To increase awareness of substance use and abuse in the context of domestic violence, sexual assault, and other forms of trauma.

2. To provide tools for advocates and community partners seeking to provide competent, trauma-informed training in their community.

Training Objectives

1. Increased competency and comfort levels for advocates and community partners providing training to local service providers.

2. Increased understanding of the effects of substance use/abuse as a coping tool, a service barrier, and a mechanism of control experienced by survivors of domestic violence and sexual assault.

3. Increased capacity to implement new practical skills to better provide trauma-informed services, including advocacy, safety planning, documentation, referral, and program accommodation.

Training Philosophy

The philosophy embedded in this training module is one of inclusion. The module is best delivered in partnership. Advocates and local service providers can model the importance of establishing empowering and healing relationships by providing community training together.
Training Teams

A training team can best model relational trauma-informed principles. Working together, the team can offer consistent, culturally relevant training for better safety, health outcomes, and wellness within their local community. Parts of the training module are complex, and an interdisciplinary team comprised of trainers with expertise drawn from both the advocacy and treatment arena will enhance the training experience and serve as a learning and growth opportunity both for the participants as well as the trainers themselves.

Before Beginning

This module is a basic tool. Trainers may use some materials exactly as they are provided or creatively adapt! Choose slides and exercises you can use as additions to your own training materials. The materials provided here give you the option to pick and choose. You can deliver a one-hour training or choose from an array of activities to provide a training that takes you from an hour to three days.

Feel free to change fonts, template, or pictures. For example, you can substitute the pictures included in this module with items that culturally resonate within your community.

Before providing training, co-trainers are encouraged to meet, divide up tasks, and determine local cultural considerations, values, challenges, and resources. You will need to discuss the agenda and clarify roles. Teams should practice exercises and prepare for training together. Remember, you don’t need to do every exercise or activity mentioned — pick those you feel will be most effective for you to meet your training goals. Training partners also need to discuss how they will handle difficulties, such as participants who struggle with the ideas presented in the training, who make oppressive remarks, or who seem disengaged.

Ground Rules and Emotional Safety

This training module is rooted in the experience of survivors and their children. Many participants themselves have experienced trauma stemming from substance abuse coercion or the experience of a substance use disorder. Participants may be reminded of prior experiences by elements of our training. Always acknowledge survivors may be in the room, offer options for people to opt out of activities and exercises, and make sure designated support people are available to debrief with anyone needing emotional assistance.

Training on topics relevant to those in recovery often draws participants in recovery to the table. Please make sure you provide resource lists of peer support meeting options, make sure quiet space is available, and provide opportunities for activities that are not connected to bars, casinos or other venues where drinking is the major focus, to make the training experience safer, more accessible, and welcoming for participants in recovery.
Teaching Tools

This module is provided to you with the following components:

1. **Trainer Introduction and Approach:** Familiarize yourself with this introduction first. This serves as a basic content guide and provides you with a quick, yet detailed, overview of this curriculum.

2. **PowerPoint Slides:** PowerPoint slides are provided for trainers to pick and choose from. These slides can be used in a variety of ways and work well when they are incorporated into your existing material. Trainers will not necessarily deliver all the material provided but can select what pieces meet their goals best. Suggestions and guidance are offered with each slide.

3. **Trainer Guidance and Essential Learning:** Review the notes that go with each slide. Trainer Guidance and Essential Learning Concepts are provided for each slide.

4. **Discussion Questions, Optional Activities, and Scenarios:** The curriculum provides various training options including suggested discussion questions, optional activities, and scenarios. Trainers are encouraged to devise their own role-plays, scenarios, and training materials to ensure cultural considerations within their own communities are addressed. Trainers are also encouraged to include knowledge drawn from their own training, expertise, and experiences within their community as well.

5. **Handouts:** This module includes handouts to support the learning material provided on the slides. Review these items and determine which materials best assist you with meeting your training goals in your local community. These handouts have been provided in the manual.

6. **References and resources:** Slide citations, a reference list, and a resource section are provided for Trainers of this module. Knowledge of current literature is highly recommended. Trainers will also want to supplement these resources with culturally relevant data that resonates with their own community.

7. **Soon to Come:** Sample pre- and post-tests are currently being developed to administer before and after training. Pre- and post-tests let you evaluate participant knowledge as well as help you to assess participant comfort level before and after receiving the training information. Pre- and post-tests are great tools to help you measure outcomes and trainer effectiveness.

Adapt Materials

The curriculum is set up to be a guide rather than a mandate. Materials are provided to you electronically in PowerPoint format as well as in printed format. Suggestions are provided for adaptation, but trainers will need to factor in considerable planning time.

While trainers can deliver materials as is, it is not recommended. Trainers are encouraged to pick and choose slides that best serve their training needs and goals.
based on what training participants need and want to learn. Ideally Trainers will incorporate these materials into their existing training tools, as well as develop their own slides and handouts to add to those provided. This will increase the likelihood materials will be both culturally relevant and responsive to the needs existing in your community.

This training module is designed to function like an accordion. You can expand or compress your training depending on time constraints and audience. Most slides can be delivered as written with or without doing an activity. Slides (and activities) can also be modified or eliminated. Many slides carry similar themes or messages.

Remember, repetition and recapping is critical:

1. Repetition re-enforces key concepts when time permits.
2. Repetition of key points makes it possible to compress the training.

Overview of Slide Content

This module contains 60 slides, with time estimates given for each section. Feel free to redo the order of the slides to suit your unique training needs. Sections include:

**Slides 1-2: Training Rationale and Optional Opening Skit Activity**

*Time: 5 minutes (Add 15-20 minutes if skit is included.)*

The key concepts in Slide 1 offer a rationale for providing this module and identify a framework for introducing the topic of substance abuse in the context of domestic violence/sexual assault and trauma-informed services. You may briefly discuss these points. Should time be limited, an optional handout providing greater detail is available for participants to review that can be given to participants at the beginning of the training.

The interactive skit in Slide 2 serves as an icebreaker to begin the process of looking at interdisciplinary services and identifying how working together can benefit the people we serve. It is excellent as an icebreaker at the beginning of a training but also very good right after lunch to energize training participants. Trainers will need to do considerable preparation work. The handout “Mary Has All Kinds of Troubles” describes the purpose, process, and how to debrief. Take a few minutes to read and review the script.

**Slides 3-7: Scope of the Issue and Prevalence Data**

*Time: 5-10 minutes (Add 10-15 minutes if discussion questions are included.)*

Prevalence data is provided. Pick and choose which statistics will be helpful with the audience you are training. It is not necessary to use each one of these slides or all the data provided. Select the data that best supports your training objectives and the needs of the training participants. Trainers can enrich the relevance of these slides by adding data reflective of prevalence in their own community or program.

It may also be useful to ask participants what kind of numbers they are seeing in their
programs. Validate how challenging it is to provide accessible services for so many survivors affected by substance use but remind participants it is our ethical responsibility to do so.

Note: The term “substance use disorder” is often used interchangeably with terms such as chemical dependency, substance abuse, or addiction. However, substance use disorder is currently considered the proper term per the update of the DSM-V.

Slides 8-11: Service Barriers
Time: 8 minutes (Add 15 minutes if the optional training activity is included.)

This section describes effects of substance use as a barrier to services, health, and safety, and can be used as a brief overview. It also serves as an opportunity to explore the impact of substance use on many levels, and begins the process of linking prevalence and the existence of service barriers to our ethical responsibility to provide accessible services.

You can select which barriers you want to address and save others for a follow-up training when time is limited. Trainers should determine which barriers reflect conditions in their community and consolidate slides rather than deliver all the material at once.

Slides 12-14: Addiction is a Feminist Issue (Effects of Substance Use Disorder on Women)
Time: 5-10 minutes (Add 10-15 minutes if discussion questions are included.)

These slides explore the experience of a substance use disorder (addiction) in terms of gender bias and begin the process of identifying the relevance of gender responsive, non-oppressive services. It is not necessary to use all the material on all the slides to get your point across. When time is limited, trainers are encouraged to select key points designed to link supporting women’s experience of a substance use disorder to oppression and sexism.

Slides 15-18: Safety Concerns for Survivors Linked to Trauma, Substance Use, and Substance Abuse Coercion
Time: 6-10 minutes (Add 10-15 minutes if discussion questions are included.)

Note: Substance Abuse Coercion is a method engaged by many people who are abusive as a means of power and control in the context of an intimate partnership. Substance Abuse Coercion can take many forms, including being forced to use substances or use more than desired, having an abusive partner leverage substance use as a threat to have children taken away, documentation status compromised, or job benefits compromised, and being told the police wouldn’t believe abuse was happening because the survivor was under the influence or was a substance user.

These slides address safety concerns affecting survivors of domestic violence and sexual assault linked to trauma, substance use and misuse, and substance abuse coercion. Substance abuse is explored as a mechanism of power and control. Survivor tactics are also identified. This series of slides is particularly useful for advocates seeking to support survivors affected by substance use/abuse.
Trainers are encouraged to read the handout: “Substance Abuse: Building a Bridge to Safety for Survivors” by Patti Bland, adapted from a Washington State Coalition Against Domestic Violence handout, in order to be familiar with issues relevant to the Essential Knowledge provided in this group of slides. You may find it helpful to pass out the handout, “Safety Issues and Multi-Abuse Trauma” to participants as well. This handout provides more information about the key points you are covering.

Encourage participants to share these and other handouts provided throughout this training with their co-workers, and also with survivors seeking support in one-to-one or group settings. Slides in this section may take 2 to 3 minutes each to explain. Several handouts are provided for the instructor to utilize or provide to participants for review later.

**Slides 19-21: Women Talk about Substance Abuse and Violence**
*Time: 5-8 minutes (Add 30 minutes if optional training activity is provided.*)

Trauma-informed services are survivor centered and survivor directed. In these slides, survivors of substance abuse coercion, a substance use disorder, and domestic violence/sexual assault share what they need and discuss what happened to them in their own words. These slides help build empathy, help put a human face to the data, and help make the material resonate in a very real way.

Feel free to talk to survivors in your own community and add their quotes to your training materials with their permission. This can be empowering for those who are asked to share their experience, strength, and hope. Survivors who have shared their words with the authors of this curriculum say, “Where have we gone this week? Who heard our voices? If we can make a difference and help someone, then our experience was not in vain…”

*Note: Remember to make sure quotes are non-identifying, and get a signed release of information indicating you have their permission and will not use information that may identify the survivor.*

**Slides 22-26: Physiological and Pharmacological Effects of Alcohol and other Drugs**
*Time: 20-25 minutes*

These slides define terms and describe effects of substance use on the brain and body. Some advocates are anxious about presenting this section. Partnering with a substance abuse treatment professional or person in recovery may help overcome this hurdle. Trainers may also consider incorporating video clips to help them present this section of the material.

Trainers are strongly encouraged to explore resources and set aside time to read recommended materials for this section of the training. While neither necessary nor required, expertise and comfort level teaching and understanding this material may increase for Trainers and advocates who take a community college level or on-line introductory course on alcohol and other drugs. NCDVTMH also encourages trainers to contact us if they require additional technical assistance or have questions or concerns.
about how to best deliver this material.

Note: While it is not necessary to understand physiology and pharmacology in depth it is impossible to provide adequate services—advocacy, safety planning, or accessible service accommodation—if advocates do not understand effects of substances on the brain (memory, thinking, craving) as well as on the rest of the body (overdose, withdrawal) because these concerns will serve as significant barriers in multiple arenas. (For example: “I want to follow the safety plan but can’t remember it,” or “I want to not drink but my hands are shaking. If I have just one that will stop and I will stop hurting.”)

**Slides 27-32: Advocate Experiences That May Be Evoked, Elicited, or Activated**

Time: 12-20 minutes (Add 10-15 minutes if discussion questions are included.)

Some responses evoked by the experience of trauma can become service barriers. These slides describe behaviors and circumstances associated with substance use that can be challenging experiences for advocates and others.

Slides 27-28 describe how unacknowledged memories, feelings, and emotions may be elicited when advocates interact with survivors experiencing a substance use disorder or other trauma that can cause concerns and act as service barriers. Slides 29-32 describe specific behaviors and circumstances associated with substance use that can evoke past experiences and cause concern for advocates and other providers.

You do not need to cover all the material on slides 29-32 in depth if you are short on time. However, it is useful to make sure folks understand that these are cues or indicators of possible substance use rather than a diagnosis of a substance use disorder. Additionally these cues may indicate something else. It is also quite likely these cues will cause concern for advocates and may elicit feelings and emotions that get in the way of service provision as well as pose a possible safety risk for the survivor experiencing the indicator.

Before teaching this section trainers should advise participants:

This process we are talking about here is often described as “triggering.” However, a growing number of survivors and their allies are describing this experience not so much as triggering but as evoking, eliciting, or activating a memory or feeling.

For some, the term “trigger” seems to imply the elicitation of memories, feelings, or emotions caused by another, rather than coming as a direct response to an individual’s own life experiences. For this reason, it is helpful for advocates and other providers to be aware that their own attitudes, beliefs, and actions may be stemming from emotions occurring now that are based on past life experience. Emotions such as fear, anger, suspicion, and concern may be elicited unexpectedly. Internal beliefs and attitudes formed in the past may be steering our internal response as well as our actions. We may be responding to our own past, rather than what is actually happening in the moment. This can lead to stress, discomfort, and feeling overwhelmed. It also can negatively affect our ability to provide services appropriately. This may occur when we see, hear, smell, taste, or touch something that brings up recollections of interactions when substance use was a factor.
Note: Slides 27-32, like any part of this manual, are optional. However, if slides 27-32 are not used in this training, the trainer may want to be sure to incorporate Slides 33-35 after Slide 26, since they also serve to remind participants how and why being aware of our own “stuff” is important.

Slides 33-35: Recap of Harm Facing Survivors Using Alcohol and Other Drugs
Time: 6-9 minutes. (Add 10-20 minutes if optional activity is included.)

If section on cues and concerns (Slides 27-32) is omitted, use these slides after Slide 26. If previous section is included, these slides serve to remind us how and why being aware of our own “stuff” is important. This group of slides also reminds us why it is our ethical responsibility to provide services for survivors affected by the experience of a substance use disorder. We cannot let negative attitudes and beliefs about people who use substances interfere with our responsibility to work on behalf of survivors experiencing a substance use disorder or substance abuse coercion.

Slides 36-43: Working with Survivors Experiencing Substance Abuse, Part 1
Time: 20-25 minutes (Add 12-25 minutes if optional training activity is included.)

These slides (and Part 2 slides 44-48) describe what to say, what to do, and what might get in the way as we strive to provide advocacy and safety options. If you have covered slides 16 and 17 earlier, there is some repetition, particularly for Slide 43 on memory. This section can be taught as a practical, stand-alone session especially if accompanied by follow-up Slides 44-48.

Note: Slides 15 and 16 provide an overview and are used to help advocates see how safety and substance use issues are intertwined. These slides (36-43) are more practical and service provision oriented rather than focused on explaining concepts. Slides 44-48 can follow and serve as an opportunity to practice and reinforce learning.

Slides 44-48: Working with Survivors Experiencing Substance Abuse, Part 2: Sample Framing Questions
Time: 10-20 minutes depending on level of detail and practice time

This section provides practical tips for talking to people about use in the context of safety and program accommodation. A series of questions and statements are provided to give advocates and allied providers the words to begin talking about substance use.

This group of slides reframes material you have begun to discuss during the training; however, during this section you may want to make time for participants to practice actually saying the questions/comments so they can identify what works for them, what may be stopping them from talking about these issues, and what else they feel they need to know. It can be useful to brainstorm with the group.

Slides 49-53: Working with Survivors Experiencing Substance Abuse, Part 3: Safety Planning when Domestic Violence/Sexual Assault and Substance Abuse Happen Simultaneously
This section provides more practical tips for talking to people about substance use in the context of safety and includes a Mini-Safety/Sobriety/Wellness Plan.

**Slides 54-60: Forging Partnerships**
*Time: 8-12 minutes (Add 3 minutes for participants to fill out a post card as recommended on slide 60.)*

These slides stress collaboration. Trainers using this module should add relevant local resources here. This series of slides helps training participants think about next steps, reviews critical points, and offers suggestions for participants to consider when they return to their community.

**About Optional Discussion Questions and Scenarios to Accompany Slides**

**Purpose of Discussion Questions:** Discussion questions can be useful in small group training sessions or used as part of a brainstorming exercise for larger groups. Several optional discussion questions are provided with the slides to help you facilitate critical thinking during your training.

The questions can be used as part of the training. They can also be asked of participants in advance to determine what are the critical issues, concerns, and beliefs held by advocates and providers in your local community. These discussion questions are also useful for discussion in the following settings: focus groups, telephonic training, brown bag lunches, or conversations with advocates, service providers, or other interested parties.

**Process:** All questions are optional. It is helpful for you to do a little research before facilitating these discussion questions in order to familiarize yourself with the issues currently existing in your community. You may also have more relevant questions of your own which will resonate better in your community.

Before engaging in training using discussion questions, trainers are responsible for doing some critical thinking of their own. Most of the questions are fairly general, so it may be useful to find out what prevalence data exists in your own state. Also, some section questions become more complex once you reach Slide 11. It will be important to review the Trainer Guidance and Essential Learning for each of the slides, as well as have a preliminary discussion with your training partner and others before facilitating a conversation.

Once you begin having these discussions, it is useful to take notes about what you learn from these questions and evaluate whether changes in attitudes and beliefs occur post-training and over time. The discussion questions can also be used in focus group settings where notes can be taken or the conversation can be taped with permission. The answers can serve as the basis for grant writing, training and protocol development, changes in services, and how we best partner with our community allies.
Debrief: It is helpful to summarize key points of the discussion with training participants post-discussion, as well as to talk about next steps. It can also be useful to provide a summary of the discussion in electronic, taped, or hard copy format to participants a week or two after the training. Feel free to solicit feedback and ask participants if anything else comes to mind. Information learned in these discussions and discussion follow-ups can lead to the development of newsletter articles, training tools, and enhanced program policies and protocols.

Reminder

This curriculum is designed to be a flexible training tool. Our immediate objective is to prepare advocates to provide effective, culturally responsive training on substance use and abuse in the context of domestic violence and sexual assault.

Providing thoughtful training through a trauma lens is best done by working in partnership and getting input and feedback throughout the training process. We believe successful trainers form and model effective, inclusive working relationships with local community service providers. Successful trainers also ensure their training is rooted in the experience of survivors and their children.

It’s all about the relationship! Everyone is included and relationships are strengthened – a true example of trauma-informed, empowering, anti-oppressive, community defined training and program development.

Final Words of Wisdom

1. Check equipment. Nothing is more frustrating than PowerPoint and other audiovisual equipment that isn’t working. Check audiovisual equipment well before training.

2. Before training starts, distribute handouts, have participants sign in, and distribute pre-tests if you plan to use them.

3. Introduce yourself and conduct introductions, setting a positive tone and creating a comfortable atmosphere. Acknowledge survivors in the room and let them know you value their presence.

4. Provide participants with an overview and an agenda. Make “housekeeping” announcements, including how you hope to provide options for the participants’ emotional safety (for example: safety room, support staff, breaks, etc.) during the training.

5. Stick to the schedule when possible, but be flexible and willing to shift gears.

7. Avoid directly confronting participants. When things get heated, don’t argue. Draw others into the discussion to present a contrasting viewpoint. Dialogue cultivates good learning. Include humor as a tool to facilitate creative thinking.

8. Defer discussion when participants get stuck on one point. Move on without cutting off participants or discounting diverse points of view. Let participants know you will re-visit their points later and be sure to do so. Have a “Parking Lot” for participants to write down what other information they would like to discuss and get back to them before the training ends, or schedule a time for further discussion by phone or email.

9. Discuss the rationale behind policies and procedures you recommend.
10. Address the group, not the screen. Avoid reading directly from the screen. Instead, use notes and face audience.

11. Keep it simple. Discuss one point at a time.

12. Cite references and let participants know limitations of data.

13. Repeat questions asked by participants in the audience. This ensures everyone hears the question and is especially important when training a large group.

14. Use a microphone whenever possible to ensure people in the back and those who have difficulty hearing are accommodated (preferably hand-held or lavaliere). Also, have a microphone available for use when participants ask questions. This is helpful for both questioners, who may not have a voice that projects well, and also for listeners, who may have difficulty hearing.

15. Make sure interpreters are available for participants who use sign language as well as for other participants whose first language may not be English.

16. If training exceeds an hour, take a break after no more than the 50-minute mark. People generally retain very little info past the 50-minute mark. When training resumes, briefly recap where you left off. This is especially important if you have gone on longer than 50 minutes before breaking.

17. Refer participants to the National Center for Domestic Violence, Trauma and Mental Health for more information at http://www.nationalcenterdvtraumamh.org/.
For information on our webinars and web series about domestic violence/sexual assault, trauma and substance abuse see: http://www.nationalcenterdvtraumamh.org/trainingta/webinars-seminars/.
Webinars are free and available for training participants to download and review.
Slides and Notes Pages
Slide 1: Substance Use/Abuse in the Context of Domestic Violence, Sexual Assault, and Trauma

Trainer Guidance:

The key concepts below offer a rationale for providing this module and identify a framework for introducing the topic of substance abuse in the context for domestic violence/sexual assault and trauma-informed services. You may briefly discuss these points. Should time be limited, an optional handout (see below) providing greater detail is available for participants to review and can be given out at the beginning of the training.

Essential Learning/Module Key Concepts:

- **Safety and Empowerment:** Providing trauma-informed services involves working together to better accommodate survivors of DV/SA in an empowering and non-judgmental manner. It is crucial for advocates and community partners to understand how substance use, substance abuse coercion, and the experience of a substance use disorder can affect survivors’ safety, agency, and access to services.

- **Our Mission – Inclusion and Anti-Oppression:** Recovery status is a disability rights issue. Women who misuse substances frequently experience bias and stigma and are routinely denied access to DV/SA services and affordable treatment due to factors beyond their control. Advocates and other service providers should explore not only the limits of the law, but also what stops us from doing more to support survivors.
• **Collaboration:** Community-based training works best when advocates establish relationships with collaborative partners in the substance abuse field who are knowledgeable about DV/SA and willing to share resources, co-train, and provide information about substance use from a feminist perspective.

• **Education:** Addressing substance use in the context of Trauma and DV/SA is complex and requires training. Substance use effects thinking, behavior, memory, and emotions. It affects human beings across all aspects of their being and serves as a barrier to safety, agency, and access to services.

**Handout:** *Substance Use/Abuse in the Context of Domestic Violence, Sexual Assault, and Trauma*
Optional Training Activity

- Mary Has All Kinds of Troubles

**Trainer Guidance:**

This interactive skit serves as an icebreaker to begin the process of looking at interdisciplinary services and identifying how working together can benefit the people we serve. It is excellent as an icebreaker at the beginning of a training session, but also very good right after lunch to energize training participants. Trainers will need to do considerable preparation work. The handout “Mary Has All Kinds of Troubles” describes the purpose, process, and how to debrief. Take a few minutes to read and review the script.

**Essential Learning:**

- Survivors will get labeled based on a number of factors including what door they enter looking for help. Things are not always as they seem and we need a number of lenses.
- Working together can give us clearer vision and better capacity to provide survivor-defined, trauma-informed services.

**Discussion Questions:**

1. Can anyone relate to what you just saw?
2. What stood out for you the most?
3. What other labels might someone be burdened with?
4. What feelings did this bring up?
5. How can providers make sure that people are not re-victimized when they seek help?
6. What does respectful advocacy or treatment look like?
7. How should Mary have been treated?
8. What steps can be taken to ensure that people’s needs are met?

**Handouts:** Skit: Mary Has All Kinds of Troubles (Script), Skit Instructions
The Scope of the Issue

- In a 2012 review of the literature, 22–72% of DV shelter residents have current or past problems with alcohol or other substances (Shumacher and Holt, 2012)
  - A study of Illinois DV shelters reveals 42% of service recipients abuse alcohol or other drugs (Bennett & Lawson, 1994).
  - 1 in 4 women in an Iowa shelter/safe home sample had a lifetime diagnosis of alcohol dependence; another 1 in 4 had alcohol or other drug problems (Downs, 2002).
  - Between 55 and 99 percent of women who have substance abuse issues have been victimized at some point in their life; between 67-80% of women in substance abuse treatment are DV victims (Cohen et al, 2003; Downs, 2001).

Slide 3: The Scope of the Issue

Trainer Guidance:

Slides 3-7 contain prevalence data. It may be useful to ask participants what kind of numbers they are seeing in their programs. Validate how challenging it is to provide accessible services for so many survivors affected by substance use but remind participants it is our ethical responsibility to do so.

Essential Learning:

- Prevalence data for individuals receiving services ranges from 50% to 90+% depending on whose research you cite and what setting you are discussing.
- The sheer scope of the problem may seem overwhelming but it is critical to talk to everyone we serve about substance use from the context of domestic violence and sexual assault. This empowers survivors to explore how substance use and substance abuse coercion affect their safety, decision-making, and ability to access services.

Discussion Questions:

1. How big is the problem of substance abuse in your community?

2. What have you learned from program participants about how substance use impacts their safety, empowerment, and access to services?

3. What is your ethical responsibility to provide services for survivors impacted by their
own or another’s substance use, abuse or addiction?

References:


Downs, W.R., Department of Social Work, University of Northern Iowa. Personal communication with Patricia Bland, April 2002.

Co-Occurring Problems

- A National Institute on Drug Abuse study noted 90% of women in drug treatment had experienced severe domestic and/or sexual violence from a partner during their lifetime (Miller 1994)
- Women who have been abused are 15 times more likely to abuse alcohol and 9 times more likely to abuse drugs than women who have not been abused (Shipway, 2004)

Slide 4: Co-Occurring Problems

Trainer Guidance:

The data on these slides is powerful when presented to interdisciplinary groups. Alcohol and other drug professionals learn how prevalent domestic violence/sexual assault is for women in treatment settings and advocates see data associating increased safety risk with alcohol and other drug abuse.

Essential Learning:

- Depending on whose research you cite and how researchers define a substance use disorder, the rates in this country range anywhere from 3-4% up to anywhere from 8-15% of the general population. Rates of domestic and sexual violence experienced by women in the general population range from 1 in 3 to 1 in 5.
- In contrast, the numbers on this slide are positively staggering and point out how important it is for advocates to provide outreach to survivors and their children receiving services in alcohol and other drug treatment programs as well as to include substance use as an element addressed in safety planning.
- It is also critical to provide information and education about domestic violence and sexual assault to alcohol and other drug counselors and professionals as well as to factor in domestic violence/sexual assault in a recovery or treatment plan.

Discussion Questions:

1. What is your ethical responsibility to provide services for survivors affected by their
own or another’s substance use, abuse, or substance use disorder?

2. What are you and your programs doing to provide trauma-informed support for women in recovery in your programs?

3. What kind of outreach do you provide for service recipients of alcohol/drug treatment programs?

4. Have you established collaborative relationships with alcohol/drug treatment providers?

5. What works well and what are the challenges?

6. Are hypothetical consults risky in rural of small communities?

7. What safety planning options do you consider when you are concerned substance abuse coercion is happening to a person you are serving?

8. How do you get feedback from survivors affected by their own or another’s substance abuse about what kind of trauma-informed support and accommodations they need?

References:


Slide 5: Scope of the Problem

Trainer Guidance:

This slide is most useful to present at trainings where both advocates and alcohol-drug treatment professionals are present. Ask participants what kind of numbers they are seeing in their programs. Validate how challenging it is to provide accessible services but remind participants it is our ethical responsibility to do so and we can do it best by working together across disciplines.

Essential Learning:

- The majority of women in alcohol and other drug treatment have experienced sexual abuse or sexual assault. In most cases survivors have been told if they had not been drinking or using this would not have happened. The most helpful message we can offer is: “This is not your fault. You don’t deserve this. No one has the right to hurt you whether you are sober or not.”
- The American Medical Association numbers presented here are overwhelming. Alcohol-drug treatment programs should routinely refer family program participants to domestic violence/sexual assault programs for follow-up, safety planning, and support.
- Many women experiencing domestic violence/sexual assault within a relationships with partners in treatment are referred to Al Anon, Nar Anon or couples counseling rather than to domestic violence or sexual assault agencies, which can increase risk especially if
a safety plan is not in place.
• Batterers and sexual offenders are people who hurt others. They often use substances as a mechanism of power and control. People who hurt and control others may also actively work to prevent survivors from engaging in recovery efforts.

Discussion Questions:

1. The AMA numbers presented here are so overwhelming; alcohol-drug treatment programs should routinely refer family program participants to domestic violence/sexual assault programs for follow-up, safety planning, and support. Despite this, most women in relationships with partners in treatment are referred to Al Anon, Nar Anon or couples counseling. How do you respond to that?

2. How often do your respond to a direct referral from a substance abuse treatment program or a domestic violence/sexual assault program? Tell me more about that.

3. What are the benefits and challenges to collaboration between substance abuse treatment programs and domestic violence/sexual assault programs?

4. How does your working relationship with your local substance abuse treatment programs affect survivors of domestic violence or sexual assault and their children?

5. How does your working relationship with your local domestic violence/sexual assault program affect treatment participants and their families?

References:


See also:
addictive behavior. *American Journal Orthopsychiatry* 59(4) 542-549.
In another study, 104 of 105 women drug users experienced physical/sexual abuse & trauma (Fullilove et al., 1993)
- 59% reported PTSD symptoms including:
  • Sleep Disturbances
  • Anxiety
  • Hypervigilance
  • Numbing of responsiveness

Trainer Guidance:

After reviewing info on this slide with the group, the Trainer may begin by stating: “People who experience trauma across multiple axes may also experience a synergistic or potentiating effect which can best be described as 1 + 1 = 10 tons of trouble. In simpler terms, the sum of all these problems is much greater than the whole in terms of survivors experiencing risk for developing symptoms of PTSD.”

Trainers should next review essential learning with the group. If time permits, Trainers may add the following factoid if the group wants information about prescription drug misuse, PTSD, and alcohol facilitated sexual assault:

- Lifetime posttraumatic stress disorder, other forms of substance use/abuse, and a history of drug or alcohol facilitated rape are significantly associated with increased likelihood of non-medical use of prescription drugs (Brady et al., 2004; McCauley et al., 2009).

Essential Learning:

- People experiencing reasonable fear from the occurrence of domestic violence or
sexual assault;
• People experiencing trauma, oppression, or discrimination;
• People experiencing psychiatric disabilities;
• And people experiencing physiological and emotional symptoms related to substance use or a substance use disorder can all experience the above symptoms.

**Discussion Questions:**

1. How do we respond to people experiencing these difficulties in our programs?

2. What accommodations are available to help people experiencing these symptoms feel safe and welcome?

3. When and how do we make a referral and to whom do we make it?

4. How do we make it safe for people to share their fears about these symptoms?

5. What kind of information do you have in your programs to help people understand what assistance is available?

4. Advocates are not working as clinicians, so what can you do to universally support the people you serve who are experiencing these reasonable responses/symptoms?

5. What options are available to help staff support survivors experiencing multiple forms of trauma in your community?

**References:**


Trainer Guidance:

A 2005 survey by the Centers for Disease Control found women who have experienced interpersonal violence are more likely to engage in heavy or binge drinking compared to women who have not experienced interpersonal violence (see http://www.cdc.gov/mmwr/pdf/wk/mm5705.pdf). Additional information about patterns of use in interpersonal violence survivors can be found in Chapter 2 of Substance Abuse Treatment: Addressing the Specific Needs of Women, on the SAMHSA web site: http://www.ncbi.nlm.nih.gov/books/NBK83243/.

Essential Learning:

- Domestic violence and sexual assault are not caused by the experience of a substance use disorder; however, there is evidence that risks to safety, recovery, agency, and access to services increase when a person experiences intimate partner violence and substance abuse simultaneously. *Note: Often, legal definitions of domestic violence include incidents of interpersonal violence, which is different from intimate partner violence. Interpersonal violence can include any violence between people within or outside of families, while intimate partner violence specifically focuses on violence within a couple or spousal/ intimate relationship and is typically understood as a type of interpersonal violence.*
• Negative attitudes and discrimination against women who experience a substance use disorder benefit batterers and sexual offenders. They count on a poor system response to survivors.
• Any failure to provide services to survivors affected by substance use or substance abuse coercion is both a form of system-sanctioned oppression as well as active collusion with batterers, offenders and people who hurt others.

Discussion Questions:

1. How might the numbers above reflect batterers’ and offenders’ use of substances against their partners?

2. How do you deal with safety concerns and confidentiality?

3. In what very limited circumstances can confidentiality be waived?

4. How much or how little information about alcohol and other drug use should be disclosed and to whom?

References:


Service Barriers

- Women impacted by multiple issues are often ill-served in our programs, and perceived as disruptive when their substance use or psychiatric symptoms become evident (Bland, 2008).

- They often need our services the most yet are among those least likely to seek or receive services. When they do not receive services their children also remain invisible and at risk (Bland, 2008).

Slide 8: Service Barriers

Trainer Guidance:

Slides 8-11 include a list of barriers to services. These barriers contribute to a lack of trust experienced by many survivors affected by substance use or substance abuse coercion (Edmund & Bland, 2011; Bland, 2014). After reviewing these barriers with training participants ask them to identify what barriers exist in their own communities. If no one mentions trust, ask the participants if they think lack of trust might be a barrier to services. Follow up by discussing the Essential Learning concepts listed below.

You may choose to provide participants with the handouts listed below to take home and review later. The first handout identifies barriers to trust, the second identifies what advocates can do to earn trust, the third identifies barriers to trust and provides a rationale for trauma-informed services. If time permits, have the group identify what resonates and what else is needed to support survivors of domestic violence/sexual assault in your community in a trustworthy way.

You can also encourage participants to view the webinar “Building Trust: Trauma-Informed Advocacy with Survivors of DV/SA Experiencing Addiction” (Webinar 2) which is one of 8 webinars addressing domestic violence/sexual assault and substance use issues available at the National Center on Domestic Violence, Trauma and Mental Health website: http://www.nationalcenterdvtraumamh.org/trainingta/webinars-seminars/2013-
**Essential Learning:**

- People who experience multiple barriers have often been traumatized.
- People who have been traumatized 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.
- Trauma-informed service provision recognizes that it takes time and effort to develop trust. To accomplish this goal, we ourselves must be trustworthy and nonjudgmental.

**Discussion Questions:**

1. What kind of relationship do you have with the people you serve? How do you evaluate this?

2. What is working well and what is stopping you from providing trauma-informed services?

3. How do service barriers impact the people we serve and their response to us and other system providers?

**Handouts:**

*Trust Isn’t Always Easy*

*Gaining Trust*

*Trauma-Informed Services: It Takes Time and Effort to Build Trust*

**References:**


See also:
Service Barriers

- Women impacted by multiple issues are often ill-served in our programs, and perceived as disruptive when their substance use or psychiatric symptoms become evident (Bland, 2008).

- They often need our services the most yet are among those least likely to seek or receive services. When they do not receive services their children also remain invisible and at risk (Bland, 2008).

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2. What is working well and what is stopping you from providing trauma-informed services?

3. How do service barriers impact the people we serve and their response to us and other system providers?

**Handouts:**

*Trust Isn’t Always Easy*

*Gaining Trust*

*Trauma-Informed Services: It Takes Time and Effort to Build Trust*

**References:**


**See also:**

Barriers to Services

- Employment, housing, health insurance, or child custody may be threatened by public disclosure of current or past substance abuse or mental health problems
- Access to treatment due to parenting responsibilities or to shelter because of the substance abuse or mental health issues may be denied
- This can lead to isolation, blame, and shame

Slide 9: Barriers to Services

Trainer Guidance:

Begin by stating, “We are seeing more and more survivors seeking services in our programs who also experience a substance use disorder.” Read or paraphrase the information provided in the Essential Learning segment below. An optional Training Activity is also provided for you, if time permits.

Essential Learning:

In a study of 13 domestic violence shelters in British Columbia that did not refuse access to women who use substances, 72% of women screened during an 18-month period reported using alcohol or a non-prescribed drug more than five times a week, or using multiple substances at least once a month, or indicating they had a current problem with alcohol or a non-prescribed substance” (Poole, et al, 2008).

Discussion Questions:

1. What if I have had no training on substance abuse – how does that affect survivors?
2. What if I don’t have adequate training to handle persons with substance abuse
problems – how does that impact me as an advocate?

Optional Training Activity: (15-20 minutes)

Purpose: The purpose of this discussion is to link the prevalence of survivors of domestic violence/sexual assault experiencing a substance use disorder to our ethical responsibility to provide accessible program services for survivors, while providing training and support for advocates and allies working on their behalf.

Process:
• Provide participants with the handout for Slide 8: Service Barriers. This handout poses two questions and offers some answers from advocates across the country. The questions are:
  • “I have had no training on substance abuse – how does that affect survivors?”
  • “I don’t have adequate training to handle persons with substance abuse problems – how does that impact me as an advocate?”

• Advise participants they can share as little or as much as feels comfortable during this exercise. Let participants know they can opt out at any time. The point of the exercise is to determine: What is stopping us from adequately responding to survivors experiencing a substance use disorder? What is getting in our way? Rather than, “What is wrong with us?”

• After participants read the handout, have them discuss their reaction to the answers and offer an opportunity for them to discuss their own concerns.

• Since there are two questions and time may be limited, Trainers can elicit information by doing a brainstorming session or they can ask participants to break up into small groups.

• If small groups are utilized, ask each group to discuss the questions. A recorder can write down the small group responses on poster paper to be shared verbally and/or displayed in the room following the activity.

• Another option is to split the room in half. Have participants break up into small groups. Have the groups on one side of the room answer Question 1 and the groups on the other answer Question 2.

• The trainer can use a “fishbowl” process to provide feedback to the rest of the room by selecting a group from each side of the room to report back on their discussion at the end of the activity.

• Before summarizing key points and concluding the activity, the Trainer can wrap up by asking the rest of the room, “Is there anyone else who has something to share before we
“move on?”

**Debrief:**

This activity has the potential to elicit strong feelings since advocates may not have consciously acknowledged underlying feelings (fear, suspicion, frustration, resentment, anger, prejudice, lack of trust) associated with their own attitudes and beliefs regarding service provision for survivors affected by the experience of a substance use disorder. It can be helpful to acknowledge how hard anti-oppression work is. Remind participants that people experiencing a substance use disorder are also experiencing a disability. This work takes time, involves self-reflection, is on-going, and hopefully will shed light on what gets in our way rather than what is wrong with us, or the people we serve. It may be useful to identify a staff member available to support participants who may want to debrief at length.

**Handouts:**

*Service Barriers*

**References:**


### Barriers to Accessing Help

- Lack of gender-specific, family-focused services
- Caregiver responsibilities; fear losing children
- Social stigma and guilt
  - Survivors who use substances face tremendous stigma and are often considered bad mothers, bad people, bad victims, and resistant to treatment
- Fewer economic resources
- Domestic and sexual violence

### Slide 10: Barriers to Accessing Help

**Trainer Guidance:**

Women are under-represented in alcohol and drug treatment settings because they often face additional barriers when seeking help for substance use disorders. They are less likely to have access to affordable treatment, and frequently lack insurance. Women are often responsible for child-care, but the majority of treatment programs do not provide this service during treatment. Also, women are often coerced into using substances, prevented from seeking recovery, and shamed and threatened by abusive partners who find it easier to control and terrorize their partners when they are under the influence.

**Essential Learning:**

- Batterers are well aware that many domestic violence/sexual assault programs may deny or limit services when alcohol or other drug issues are present. They are also aware of the bias survivors who experience a substance use disorder face in court and in other arenas.

- This bias is compounded when the person experiencing a substance use disorder is a mother.
Discussion Questions:

1. How does sexism contribute to our response to survivors of domestic violence/sexual assault who use or misuse substances or experience a substance use disorder?

2. How can we reduce barriers for battered women impacted by their own or another’s substance use, abuse, or dependence? (Note: both substance abuse and substance dependence are now considered a “substance use disorder”).

References:

Another Barrier to Safety: Prescription for Trouble

- Research indicates women are likely to use prescription medication much more often than men
  - The results of a nation-wide survey show nearly twice the number of female users of psychotropic meds, as compared to men
    (Paulose-Ram R, Safran MA, Jonas BS, Gu Q, Orwig D., 2007)
  - A sample of 102 women who were sexually assaulted were assessed for prescription drug use, and 44% reported use of sedatives and/or antidepressants post-rape
    (Sturza & Campbell, 2005).

trainer Guidance:

Research shows that 70% of prescriptions for tranquilizers, sedatives, and stimulants are written for women (Roth, 1991). Psychotropic medication is over-prescribed for survivors of domestic violence, according to the Minnesota Coalition for Battered Women (1992). However, advocates often report feeling uncomfortable discussing concerns about medications with survivors.

Trainers and participants who are not familiar with physiology and pharmacology may feel challenged by the material. Trainers are encouraged to co-facilitate and have a health care or substance abuse professional available to take questions or deliver this slide if possible. Trainers are also encouraged to review the handout Capsule Comments: Alcohol and Pills – A Feminist Issue with participants. See also: Trainer Guidance and Optional Training Activity, Slide 9.

Essential Learning:

- Discussions about medications beyond the scope of safety planning or determining program accommodation needs may qualify as Americans with Disabilities Act or Fair Housing violations, particularly if such discussions are only held with “certain” individuals or can be linked to denial of services.
Domestic violence programs in Seattle found it useful to recruit volunteers from the health care field and the substance abuse arena to join their board as well as to visit their programs. Domestic violence providers also worked closely with nurses from Health Care to the Homeless who were available to meet privately with program participants who had questions about meds, concerns about side effects or other related issues. Generally this was much safer and less threatening for both survivors and staff.

**Discussion Questions:**

1. What role has sexism played in women’s substance dependence?

2. What kinds of information and education can you provide to support and accommodate survivors of domestic violence/sexual assault who use, misuse or are dependent on prescription drugs?

3. How does the medical system (and our system) collude with batterers?

**Handout:**

*Capsule Comments: Alcohol and Pills – A Feminist Issue*

**References:**


**Addiction is a Feminist Issue**

- Women have higher blood alcohol levels than men after consuming equal amounts of alcohol (LaGrange, 1994; Lieber, 1993).
- Women also have higher prevalence and greater severity of alcohol-related liver disease with shorter duration of alcohol use and lower consumption levels than men (Kubbs, 2000).
- Death rates from alcohol-related damage are higher for women (CSAT, 1994).
  - The rate of fatal overdoses of prescription painkillers and other drugs among U.S. women quadrupled between 1999 and 2010 (CDC, 2013).

**Trainer Guidance:**

The experience of a substance use disorder (addiction) is a feminist issue. Women experience rates of addiction similar to that of men, but need exposure to less substance use over a shorter duration of time to experience more significant health problems and greater risk for death.

**Essential Knowledge:**

- The rate of fatal overdoses of prescription painkillers and other drugs among U.S. women quadrupled between 1999 and 2010.
- According to the Centers for Disease Control and Prevention, since 2007, more women have died from drug overdoses than from motor vehicle traffic injuries, and in 2010, four times as many died as a result of drug overdose as were victims of homicide. The CDC Study, p. 539, can be found here: [http://www.nlm.nih.gov/medlineplus/news/fullstory_138362.html](http://www.nlm.nih.gov/medlineplus/news/fullstory_138362.html)

**Discussion Question:**

1. If women experience more fatal drug overdoses and higher blood alcohol levels than...
men (thus, greater intoxication when consuming equal amounts of alcohol as men), what kind of risk factors does this pose for women experiencing domestic violence and/or sexual assault?

References:


Slide 13: Women Experience More Serious Health Problems

Trainer Guidance:

Recap by stating, “Addiction is a feminist issue.” Women with substance use disorders experience more health problems more quickly than men.

Essential Knowledge:

- For women, substance abuse problems can lead to long-term health consequences and can be lethal.

Discussion Questions:

1. If death rates from alcohol related damage are higher for women and take place at an earlier age for women, why do you think women are underrepresented in alcohol drug treatment?

2. What factors do you think might contribute to a survivor of domestic violence or sexual assault deciding not to enter substance abuse treatment?

3. What might be a factor contributing to a decision by a survivor of domestic violence or sexual assault to leave substance abuse treatment against medical advice?
References:


Other Factors: Substance Use and Infectious Diseases

- Women with SUDs are more likely to have high-risk sex and multiple sex partners (U.S. DHHS, 1999)
- Women with SUDs are at increased risk for HIV, TB, hepatitis, and other STDs (Francis & Cargill, 2001)
- Drug abuse is nearly twice as likely to be directly or indirectly associated with AIDS in women than in men (Weiss et al., 2003)
- 35% of women living with AIDS in 2003 were exposed via injection drug use (HRSA, 2005)

**Trainer Guidance:**

Recap by stating, “Substance abuse is a feminist issue.” A woman’s use of substances is often viewed by an abusive partner as justification for engaging in abusive or sexually exploitative behavior. These abusive and exploitative behaviors put women at risk for HIV exposure as well as exposure to hepatitis and other sexually transmitted infections. Survivors of domestic violence have described being forced to use unwanted substances, forced to use dirty needles or cottons, forced to trade sex for drugs to support a partner’s habit, and not being allowed to use condoms.

**Essential Knowledge:**

- In 2010, women accounted for an estimated 9,500, or 20%, of the estimated 47,500 new HIV infections in the United States. Most of these (8,000, or 84%) were from heterosexual contact with a person known to have, or to be a high risk for, HIV infection.

- A CDC survey found that women who have experienced interpersonal violence have an odds ratio of 3:1 to have risk factors for HIV or other sexually transmitted infections (as compared to women who have not experienced interpersonal violence (CDC, 2012).
From 2005-2009, women were twice as likely as men to have HIV transmitted due to injection drug use. From 2005-2009, 83% of women who were diagnosed with HIV were exposed through heterosexual contact; 13% of men diagnosed with HIV were exposed through heterosexual contact (CDC, 2013).

Discussion Questions:

1. How can your program ensure routine universal infection control protocols are in place to reduce health and safety risks for both survivors and staff?

2. How might offenders use substances and HIV status to harm a partner?

3. How can an advocate provide a trauma informed response for survivors experiencing a substance use disorder and/or HIV?

References:


Safety Concerns

- Acute and chronic effects of alcohol and other drug use, or mental illness may prevent one from accurately assessing levels of danger.

- One may feel an increased sense of power from substance use or psychiatric symptoms and erroneously believe self-defense against an assault is possible, not realizing the impact of substances on gross motor functioning and reflexes (Bland, 1997; Illinois Dept. of Human Services, 2000).

**Slide 15: Safety Concerns**

**Trainer Guidance:**

While substance abuse does not cause violence, it can make a violent situation more dangerous.

Substance abuse makes it harder for a survivor to get safe for several reasons (IDHS, 2000): Substance abuse impairs judgment, which makes safety planning more difficult; the survivor may avoid calling police for fear of getting arrested or being reported to a child welfare agency; and a survivor may be denied access to shelters or other services if intoxicated.

**Essential Learning:**

- The simultaneous experience 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 (Edmund & Bland, 2011).

- 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 (Edmund & Bland, 2011).

**Handouts:**

*Safety Issues and Multi-Abuse Trauma*

*Safety Concerns: Memory Deficits and Physical Harm*

**References:**


Slide 16: Safety Concerns

Trainer Guidance:

Provide participants with the handout “Safety Concerns: Memory Deficits and Physical Harm” before reviewing the Essential Learning listed below with the class. The information covered in this slide may initially alarm advocates; however, they will be more aware of the difference between the terms “black out” and “pass out” and hopefully will be better equipped to take these factors into account when safety planning or responding to an incident at their program.

Essential Learning:

- Abusers may coerce or force partners into using alcohol or other drugs as a way to gain control over their partners.

- Memory deficits may result from blackouts and euphoric recall.

- Physical vulnerability may result from passing out, which in turn can affect safety in terms of domestic violence and sexual assault.
Handouts:

Safety Concerns: Memory Deficits and Physical Harm

Mental Health And Substance Abuse Coercion

Building a Bridge to Safety for Survivors

References:


Trauma in the Context of DV/SA Mechanism of Control: Abusers Pose Risk to Partners

- Introducing partner to drugs
- Forcing or coercing partner to use (e.g. dirty needles, cottons, noxious substances)
- Isolating partner from recovery and other helping resources
- Coercing partner to engage in illegal acts (e.g. dealing, stealing, sex work)
- Sabotaging recovery efforts
- Using drug history as threat (deportation, arrest, CPS, custody, job, etc.)
- Blaming abuse on partner use and benefiting from:
  - Lack of services for women with substance use issues
  - Societal beliefs re: women & addiction

Slide 17: Trauma in the Context of DV/SA Mechanism of Control: Abusers Pose Risk to Partners

Trainer Guidance:

*The Power and Control Model for Women’s Substance Abuse*, developed by Marie T. O’Neil, explores the intersection of domestic violence and substance abuse, and is included in the handouts section of this curriculum. Please also see *Assessing Needs from Real Tools* (2011) to help identify safety and accommodation needs post-intake and to find more versions of the Power and Control Wheel. These tools are best used for self-assessment and should not be placed in program participant files.

Trainers are encouraged to display a copy of both the Power and Control Model for Women’s Substance Abuse and the original Power and Control Wheel in the training room to serve as useful cues for visual learners. These tools can be blown up to large poster size and laminated.

After reviewing the slide material with participants, encourage those who provide support groups to consider how they can use this material in their groups. Suggest drawing the wheels on poster paper or on a white or black board with the names of the tactics but leave the space between the spokes on the wheel open for survivors to list what each tactic means to them. Survivors may also be encouraged to add tactics...
reflecting any of their experiences that are NOT included on the original wheels. Survivors may not feel safe describing their experience if there is no space for them to share what may be invisible to us but is painful, terrifying, or embarrassing for them. Invisibility is deadly because we cannot safety plan very well for unknown factors.

Scott Hampton from New Hampshire also describes batterers who seek to induce disability in their partners. The easiest way to induce disability and benefit from negative attitudes directed toward women is to use substances as a mechanism to exert power and control.

**Essential Learning:**

- The Power and Control Model for Women’s Substance Abuse was developed by Marie T. O’Neil and sheds light on how batterers use substances as a mechanism of control.

- The original Power and Control Wheel is familiar to most advocates and demonstrates how an abuser uses calculated and intentional tactics to gain or maintain “power and control” over the victim. The O’Neil wheel makes the tactic of substance abuse coercion visible and is perhaps the most useful tool you can use to help survivors identify substance use coercion as a tactic of domestic violence. It makes the invisible visible and provides words to describe the survivor’s experience of substance abuse coercion.

**Discussion Questions:**

1. In what ways have domestic violence/sexual assault programs colluded with batterers who have used substances as a mechanism of control?

2. How can offenders be held accountable for substance abuse coercion?

**Handouts:**

*Power and Control Wheel & The Power and Control Model for Women’s Substance Abuse*

*Understanding and Responding to Men who Batter Women with Disabilities* by Scott Hampton

**References:**


Adult Survival Skills

- Being devious to survive, lying to the abuser and others
- Encouraging an abuser to drink until the pass out point so no one gets hurt
- Reasoning with abusers, expressing disapproval
- Lying about abuser’s criminal behavior
- Trying to improve the relationship
- Creating internal space through fantasy that abuser can’t touch
- Having sex to placate abuser and protect children from violence
- Drinking and using drugs to numb pain

(Adapted from Ganley and Schecter, 1996)

Slide 18: Adult Survival Skills

Trainer Guidance:

Using a trauma lens helps us understand complex survival skills that sometimes seem baffling for those unfamiliar with the impact of trauma in the context of domestic violence and sexual assault. Reframing these behaviors in terms of how they make sense (rather than criticizing or judging them) is empowering. It allows us to validate a survivor’s experience as well as offer additional options and better advocate for them.

Essential Learning:

- Using a trauma lens helps us understand complex survival skills that sometimes seem baffling for those unfamiliar with the impact of trauma in the context of domestic violence and sexual assault.

- Reframing these behaviors in terms of how they make sense (rather than criticizing or judging them) is empowering. It allows us to validate a survivor’s experience as well as offer additional options and better advocate for them.

Discussion questions:
1. What are some examples of survival skills that seemed baffling until understood in the context of domestic violence/sexual assault and trauma?

2. Can you give examples of what to say and do to validate survivors?

3. What options are available to better accommodate and support program participants with the survival skills that may have unintended consequences?

4. How can understanding survival skills in the context of trauma and domestic violence/sexual assault help us better advocate for survivors?

References:


Slide 19: Each Survivor Will Tell You What They Want

**Trainer Guidance:**

Many people seeking to support survivors would like to know how to do it. Often advocates ask, “What should I do first?” The most important thing to do is to listen. Generally speaking, there are many paths to safety, sobriety, and wellness. Some survivors may express the need to get safe first. Others will want to work on sobriety, trauma, or mental health first. Some will do a little bit of this, a little bit of that depending on what concern is affecting them most at a given point in time.

**Essential Learning:**

- Survivors will tell you what they want and need when they are ready to share. How much they share and what they choose to reveal will generally depend on many factors including, but not limited to, how safe they feel.

**References:**

“I don't think I could deal with one issue alone. It was critical that I deal with the domestic violence, to get away from it, because it was just getting worse and worse. But I couldn't deal with the domestic violence if I was still getting all drugged up.”

“You've got to be sober, at least a little bit, to be able to even look at the domestic violence. But if you get sober, and you don't look at those issues, you're not going to stay sober, not in the long run.”

“I couldn't recover from substance abuse if I was still being physically abused, mentally abused, because I would be right back to using. So they walk hand in hand. I would not recover from one unless I address the other, and vice versa.”

Slide 20: This slide is a continuation of Slide 19

Trainer Guidance:

This slide, which is a continuation of the previous slide, demonstrates the many different ways survivors respond to their unique situation.

Essential Learning:

- Survivors respond to their unique situation in their own way and in their own time. There are many paths to safety or recovery, unique to each survivor.

- Both trauma-informed service provision and good advocacy take into account each individual survivor’s needs. Trauma-informed advocacy services are respectful.

- A survivor may seek safety first, sobriety first, or alternate, working on one or the other or both by making choices along the way based on the reality of what is happening at any given moment in time. There are many paths, and each person’s choices are unique. A survivor gets to decide the path – not the advocate or other helping professional.

Discussion Questions:
1. How can we best advocate for someone who wants to work on one task when we think they should work on another?

2. How can we best provide empowering, non-judgmental, trauma-informed advocacy and/or support?

**Handouts:**

*Assessing Needs*

*Women Talk about Substance Abuse and Violence*

**References:**


*See also:*

Survivors talk: About power and control...

"The drugs are an element of control. If they can keep you on the drugs, using or addicted to the drugs, they're in control. And it's like strings on a puppet. They just keep you under control because you want that other hit. You want that other drink."

Slide 21: Survivors Talk: About Power And Control

Trainer Guidance:

This slide is a continuation of Slides 19 and 20, but also reinforces earlier slides that discuss ways abusers may coerce or force partners into using alcohol or other drugs as a way to gain control over their partners. The Essential Learning section offers suggestions for ways advocates can respond when a survivor discloses this type of situation.

Essential Learning:

• If a survivor discloses that a partner abuses substances, an advocate might ask: “Many people tell me their partners don’t want to drink or drug alone. How often have you found yourself stuck using when you didn’t want to?” This is a non-judgmental way to elicit information and provides an opportunity to explore drug related domestic violence.

• Survivors experiencing substance abuse may believe their safety will be assured if they just get sober but getting sober can pose new risks. An abusive partner may increase violence as the recovering survivor becomes harder to control.

• Before talking about substance use, affirm a person’s survival and praise them sincerely for finding their own way to cope. Trauma- informed advocacy includes validating a victim’s survival strategies as well as identifying risks. For example: “You
deserve credit for finding a way to cope. Tell me what made you able to survive?

**Optional Training Activity: (30 minutes)**

**Purpose:** This exercise is designed to provide practice for participants seeking to develop nonjudgmental listening skills. Participants are given an opportunity to practice and/or observe each other listening, validating, and offering survivor-defined assistance.

**Process:** Split the participants into 3 groups. Have each group select roles of a survivor, an advocate, an observer, and a reporter. The survivor will read a quote from slide 19 to 21. The advocate will listen and then validate the survivor without offering advice. The advocate can also ask, “How can I help you?” The observer will record what happens during this conversation between the survivor and the advocate. The reporter will report the observations back to the entire group following the exercise.

*Note:* If more than 4 people are in a group, the extras can take turns responding as the advocate or taking notes as an observer. The person playing the role of advocate can validate, offer options, and seek to better accommodate the survivor, or safety plan and listen. The survivor can share as much or as little info as feels comfortable.

**Debrief:** After the exercise the observer and reporter can ask each participant how it felt playing the roles: What worked best? What would they do differently? What was most challenging? The reporter can share with the group at large what happened. If the class is large, the Trainer can select one to three recorders from around the room to report back on their group’s experience at the end of the activity. The Trainer can wrap up by asking the rest of the room, “Is there anyone else who has something to share before we move on?” before summarizing key points and concluding the activity.

**References:**


See also:

Slide 22: Substance Use Disorder (Addiction)

Trainer Guidance:

Slides 22-26 define terms and describe effects of substance use on the brain and body. Some advocates are anxious about presenting this section. Partnering with a substance abuse treatment professional and/or person in recovery may help overcome this hurdle. Trainers may also consider incorporating video clips to help them present this section of the material. The graphics in slides 22-24 are from *Uppers, Downers, All Arounders: Physical and Mental Effects of Psychoactive Drugs, 4th Edition.*

See the fact sheet “Substance-Related and Addictive Disorders” for more information about the most recent American Psychological Association DSM 5 criteria pertaining to Substance Use Disorder. Follow this link: [http://www.dsm5.org/Documents/Substance Use Disorder Fact Sheet.pdf](http://www.dsm5.org/Documents/Substance Use Disorder Fact Sheet.pdf)

Essential Learning:

- There are many definitions describing a substance use disorder which is often referred to as addiction in lay (non-medical) terms. The simplified definition by the American Society of Addiction Medicine (ASAM) is “...a disease process characterized by the continued use of a specific psychoactive substance despite physical, psychological, or social harm” (Inaba, 2003).
• Alcohol and drugs affect the brain and the body whether or not a substance use disorder is present. Substance abuse is a destructive pattern of drug use, including alcohol, which leads to significant (social, occupational, medical) impairment or distress. Often the substance use continues in spite of significant life problems related to that use. Substance use and misuse are behaviors. However, once the use escalates to the level of a disorder it is no longer merely a behavior but becomes a brain disease (Bland, 2008).

References:


Slide 23: The Liver

**Trainer Guidance:**

This slide is a continuation from Slide 22. When possible, have a substance abuse counselor briefly discuss liver and brain function in the development of a substance use disorder. It is essential to use the handout provided for use with Slides 22-24 with these slides in order for advocates to understand substance use in the context of domestic violence and sexual assault. See handout: “Understanding Survivors Experiencing a Substance Use Disorder.”

**Essential Learning:**

- Survivors suffering from a substance use disorder don’t know when they have the first drink or take the first drug what the future will hold. They expect to feel better or kill pain and find themselves believing they can control it. Unfortunately, a substance use disorder generally leads to feelings of loss of control and powerlessness.

- This loss of control and powerlessness does not mean one is weak or helpless. Instead, those who experience addiction cannot reasonably predict what will happen when they use due to liver function and brain chemistry. One is powerless only in terms of how one’s liver, one’s body, and one’s brain will respond once alcohol or other drugs are
introduced to it.

- Many people struggling with addiction don’t want to stop using alcohol or drugs. They want the craving, the problems, and the pain of withdrawal to stop. They want to be like other people who can have a social drink or take medication without serious physical ramifications.

- Unfortunately, like anyone else discovering an allergy (e.g., an allergy to bee stings), the person with an addiction, once “stung,” may forever need to avoid substances or experience life-threatening health consequences. Fortunately, we can support a survivor’s empowerment through our knowledge of options and available resources.

**Handouts:**

*Understanding Survivors Experiencing a Substance Use Disorder*

**References:**


Slide 24: Reward System of the Brain

Trainer Guidance:

Slide 24 depicts the mesolimbic dopaminergic reward pathway of the brain. “The reward system is the part of the brain most responsible for a substance use disorder – addiction in lay terms. Normally it signals pleasure when some bodily need is met. It also responds when certain psychoactive drugs are taken. This surge caused by the drugs reinforces their use and often triggers an intense craving” (Inaba, 2000, p. 49–50).

Safety and sobriety can be addressed in a trauma-informed way if we acknowledge both substance use (for example, a glass of wine with dinner), and being in an intimate relationship (for example, dating or having a partner) are common experiences both for the survivors we serve and for ourselves. This means misuse of substances or abuse within an intimate relationship could happen to anyone. This being the case, anyone could find themselves having a problem with substances or a partner through no fault of their own (Bland, 2008).

While the experiences of a substance use disorder and domestic violence/sexual assault may be similar in some ways there are also important differences. For a look at the similarities and differences, see the handout “Sorting Out Messages.”
Essential Learning:

• People experiencing addiction are often unfairly blamed for having a substance use disorder. A major symptom of this illness is to believe one does not have it. This belief plus social acceptance of drinking or taking medication to kill pain can make it very hard for survivors to seek help.

• Additionally, a batterer’s choice to coerce a partner to use substances, prevent treatment, sabotage recovery, and benefit from a lack of services for women experiencing both violence and addiction is an often overlooked form of physical and emotional violence as well as a method of exerting power and control.

• As advocates, we must remember the threat a batterer may pose to both safety and recovery for women impacted by both domestic violence/sexual assault and substance abuse issues. While withdrawal symptoms and overdose can be dangerous, addiction is treatable and long-term recovery is possible particularly when safety is assured (Bland, 2008).

• While withdrawal symptoms and overdose can be dangerous, addiction is treatable, and long-term recovery is possible particularly when safety is assured (Bland, 2008).

Discussion Questions:

1. In what ways are the experiences of a substance use disorder and domestic violence/sexual assault similar?

2. How are they different?

3. How can substance abuse professionals and advocates work together to address barriers and stigma experienced by survivors with addiction?

Handouts:

Sorting Out Messages

References:


Definitions

- **Tolerance**
  - The need for significantly larger amounts of substance to achieve intoxication

- **Withdrawal**
  - Adverse reaction after a reduction of substance

- **Substance Use Disorder (Addiction)**
  - Brain disorder characterized by continuous or periodic impaired control over drinking alcohol or using other drugs, preoccupation with use, use despite adverse consequences and distortions in thinking (e.g., denial)

Slide 25: Definitions

**Trainer Guidance**

Begin the discussion by paraphrasing or saying, “When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of substance) it is likely the person has progressed from abuse to dependence or physiological addiction. This is often progressive and can be life threatening” (IDHS, 2000).

Summarize the Essential Learning points after saying “A substance use disorder, also known in lay terms as addiction, is characterized by continuous or periodic impaired control over drinking alcohol or using other drugs, preoccupation with drugs or alcohol, use of drugs or alcohol despite adverse consequences, and distortions in thinking, most notably denial. Although one may choose to use alcohol or drugs one does not choose how one’s body will respond to that choice” (Bland, 2008; IDHS, 2000).

**Essential Learning**

- Generally speaking whatever experience a drug gives you, your body and your brain try to figure out a way to get you back into balance (homeostasis). Thus, if you experience pleasure, the rebound effect of the drug is to feel pain as it comes out of your system. If a drug (e.g. caffeine) wakes you up and helps you focus, you feel tired when...
the drug leaves and can’t concentrate. If a substance helps you sleep, you can experience sleep disruption for up to two years after last use once dependence has begun (Coughlin, 2000; Inaba, 2003).

- The opposite of calm is a seizure, which you will often see in withdrawal from alcohol and other sedating drugs. Drugs that reduce anxiety increase anxiety when they exit the system just as drugs that kill your appetite can increase it when you don’t have access to them. Withdrawal symptoms can be merely uncomfortable but can also be deadly. The most deadly withdrawal comes from alcohol and prescription meds such as diazepam (Valium) and alprazolam (Xanax), as well as other anxiety reducing drugs (Coughlin, 2000; Inaba, 2003).

**Discussion Questions:**

1. Who can we turn to in our communities if we are concerned about the possibility that a survivor is experiencing an overdose or serious withdrawal symptoms?
2. What policies and procedures does your agency have to support a survivor experiencing difficulties associated with substance use?
3. How do you deal with safety concerns and confidentiality?
4. In what very limited circumstances can confidentiality be waived?
5. How much or how little should be disclosed and to whom?
6. Are hypothetical consults risky in rural or small communities?
7. What options do you have when you are concerned?

**References:**


Distortions in Perception

- **Passing Out** - falling asleep or becoming unconscious from excessive alcohol or other drug (AOD) consumption

- **Euphoric recall** - memories formed under the influence (Johnson, 1980)

- **Blackout** - an amnesia like period often associated with heavy drinking (Kinney & Leaton, 1991)

**Trainer Guidance:**

Begin by saying: “Alcohol and other drugs distort perceptions. Survivors experiencing a substance use disorder or using a substance may have a hard time recognizing options or evaluating safety due to distortions in thinking. They also may be unable to recall events or protect themselves when they are passed out. To be passed out by definition means to be asleep or unconscious.”

Provide expanded information related to memory: “Blackouts may mean the absence of memories for some events. Experiencing a blackout does not mean a person has passed out or lost consciousness. Nor does it mean psychological blocking out of events or repression. A blackout is an amnesia-like period often associated with heavy drinking. People in a blackout may appear to be functioning normally but later have no memory of what occurred (Kinney & Leaton, 1991).

Inability to remember events poses safety problems for survivors experiencing blackouts. Problems can include being unable to recall safety plans, being unable to know how an injury was sustained while making a report to police at the time of an assault, and being unable to recollect the event mere minutes or hours later, let alone in court.
**Essential Learning:**

- The only initial memory substance users have of what happens when they use is formed when they are under the influence of alcohol or in a drugged state. Thus if survivors under the influence inaccurately assess their level of danger or perceive they are “able to handle it,” sobering up the next day may be insufficient to correct the distortion.

- This toxic thinking or distortion of perception is termed euphoric recall (Johnson, 1980) and theoretically has the potential to increase risk for survivors who experience a substance use disorder as well as domestic violence/sexual assault.

**References:**


*See also:*

Advocates’ Experiences May Be Evoked and Cause Concern…

How many have been touched by someone else’s alcohol or drug use?

**Slide 27: Advocates’ Experiences May Be Evoked and Cause Concern**

**Trainer Guidance:**

Some responses evoked by the experience of trauma can become service barriers. These slides describe behaviors and circumstances associated with substance use that can be challenging experiences for advocates and others.

The trainer can begin the session by saying, “Most people know someone who has struggled with a substance use disorder. If it feels safe for you to share, how many have been touched by someone else’s alcohol or other drug use?”

Once you see the show of hands you can say, “These experiences shape our thoughts and beliefs and affect how we do our work.”

**Essential Learning:**

- Substance abuse is a destructive pattern of use of drugs, including alcohol, which leads to clinically significant (social, occupational, medical) impairment or distress. Often the substance use continues in spite of significant life problems related to that use (IDHS, 2000). This pattern of continued use can elicit a variety of responses among staff and program participants.
• Advocates, other staff and survivors may have long-held beliefs about substance abuse and people who use substances. Sometimes people may not recognize these beliefs or even be aware of any bias. They may have relationships with individuals who have abused substances, or have experienced substance abuse or a substance use disorder themselves.

• Life experience can evoke a variety of responses for anyone who interacts with individuals impacted by substances in our programs. Emotional responses can include anger, fear, hopelessness, frustration, compassion, futility, helplessness, and generalized discomfort.

• Recognizing, understanding and knowing how these emotional responses affect us all is critical in a trauma-informed service environment.

Discussion Questions:

1. How we think and feel affects not just our feelings but also our behavior and how people respond to us. How might our feelings about substance use affect our work?

2. How might it affect us?

3. Having a plan to deal with these feelings and a system of support is an extremely important element of a trauma-informed service delivery model. What protocol and supports exist at your agency to prevent burnout, support staff, and assist survivors who are “triggered” or whose emotions are activated by indicators of someone’s substance use or substance use disorder?

References:


Trainer’s Guidance:

It is helpful for advocates and other providers to be aware that their own attitudes, beliefs, and actions may be stemming from emotions occurring now that are based on past life experience. Emotions such as fear, anger, suspicion, and concern may be elicited unexpectedly. Internal beliefs and attitudes formed in the past may be steering our internal response as well as our actions. We may be responding to our own past, rather than what is actually happening in the moment. This can lead to stress, discomfort, and feeling overwhelmed. It also can negatively affect our ability to provide services appropriately. This may occur when we see something, hear something, or smell something that brings up recollections of interactions when substance use was a factor.

Begin by saying, “Substance use and misuse are behaviors. Research supports several theories related to what causes the development of a substance use disorder including behavioral, psychosocial, cognitive, medical, and other models (IDHS, 2000; Edmund & Bland, 2011).

Essential Learning:

• Substance use and misuse are behaviors. According to the disease model, a substance
use disorder, unlike domestic violence, is not a behavior. It is a brain disease affecting every aspect of what it is to be human (Edmund & Bland, 2011).

- When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of substance) it is likely that the person has progressed from abuse to dependence and addiction (IDHS, 2000).

- While diversity of thought exists pertaining to the cause (etiology) of a substance use disorder (addiction in lay terms) it is critical to learn to recognize and identify survivors with this condition and provide appropriate options, safety planning and referrals (Bland & Edmund, 2008).

- This process can be undermined if advocates, staff, and program participants are overwhelmed by their own responses to substance abuse cues.

**References:**


Slide 29: Substance Abuse – Phone Cues that Can Cause Concern

**Trainer Guidance:**

The next few slides will describe indicators of possible substance use that can cause acute concern for advocates and others. Begin by stating “While the cues on this slide may indicate possible substance use – this is not always true.” Ask the participants, “What else can you think of that could impact speech?” Briefly brainstorm before reviewing Essential Learning below.

**Essential Learning:**

Slurred speech, long pauses, and rambling can be indicators of head injury or stroke. Problems with speech can also occur if someone has a broken jaw, teeth knocked out, or an injury to the tongue. Hearing people may also experience difficulty understanding the speech of some survivors who describe their experience as hearing impaired, hard of hearing, deaf, or as identifying with Deaf Culture.

- Rapid speech, hostile tone, and hang-ups may be drug-related but they can also indicate fear or frustration. They could be indicators of bipolar disorder or merely anger. Sounds of sipping could be water, coffee, soda, or alcohol; gulping could be vitamins, food, prescription or non-prescription medications.
• Loud background noise could indicate partying, a hearing loss, domestic violence, or other issues.

**Discussion Question:**

1. How do you explore cues that cause concern in a safe, nonjudgmental way to determine options for survivors as well as safety planning needs and referrals?

**References:**


Slide 30: Substance Abuse - Cues that Can Cause Concern

**Trainer Guidance:**

It is important to pay attention, look for patterns, ask how we can help and how we can best accommodate the people we are working with. Changes in behavior can be very telling, but one should never jump to conclusions. Be open and direct, state what you see/hear, and ask what can you do to help the program participant now because you are concerned about them, their safety, and their comfort.

**Essential Learning:**

- Chemical odors can be from drugs or from other sources (gasoline, glue, paint). Odor of alcohol is usually alcohol, not “asthma inhaler, hair spray, or mouth wash.”

- While loud, overly friendly, hostile, or argumentative speech can be indicators of alcohol or drug use, they can also be indicative of a ruptured eardrum, relief, frustration ... you name it.

- Mood shifts, bad language, and sullen looks or comments can be a reasonable response to an individual’s situation. It can be also be alcohol/drug related, an indicator of trauma, a coping strategy, a sign of depression, or other psychiatric disability.
• Difficulty with fine motor tasks is highly correlated with substance use, but it can also be secondary to injuries or disabilities such as Parkinson’s.

• Head injuries are always a possibility, especially when domestic violence, sexual assault, or substance use is part of the mix. Be particularly aware of hoarseness, which can be related to strangulation, a cold, a cough, nicotine, or other substance use.

References:


More On-Site Cues/Concerns

- Head bobbing, eyelids drooping, looks sleepy, could be hoarse, sniffling etc.
- Inflamed, eroded nasal septum
- Staggering, swaying while standing still
- Red eyes, dilated, or pinpoint pupils
- Track marks, burn marks on clothes
- Tremors, agitation, disorientation, rapid pulse/respiration
- Scratching or picking at arms or face

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Slide 31: More On-Site Cues/Concerns

**Trainer Guidance:**

After you review the Essential Learning below, wrap up Slides 30 and 31 by stating: “It is important to pay attention and look for patterns. Ask survivors questions such as: ‘You seem stressed. How can I help? What do you need to feel more comfortable and safe here? How can we best accommodate your needs?’ Changes in behavior can be very telling but one should never jump to conclusions.”

Advise advocates to be open and direct. State what you see/hear and say:

“**When I see/smell/notice/hear ________, people often tell me they are scared, overwhelmed, or using something to cope. What can I do to help you feel safer?**”

“I am worried because a lot of people tell me their partners use their substance use against them. What can I do to support you right now? I am concerned about you, your safety, and your comfort.”

**Essential Learning:**

- Head bobbing, eyelids drooping, or looking sleepy could be opiates, including heroin, pain meds or other sedating drugs such as alcohol; these could also be indicative of
fatigue, exhaustion, or narcolepsy. Hoarseness could be from alcohol or other drug use but also can be due to strangulation, a cold, laryngitis, or screaming for help. Sniffling can be a withdrawal symptom from opiates, an indicator of nasal passage damage from snorting drugs like cocaine, the beginnings of a cold, allergies, or simply be from crying, as could red eyes.

• Staggering or swaying could be from drugs or alcohol, but could also be a gross motor deficit or stem from injury – a host of things. Dilated or pinpoint pupils can be from drugs, from getting eye drops put in for an eye exam, or from a head injury or concussion.

• Tremors, agitation, disorientation, and rapid pulse/respiration can be withdrawal symptoms, particularly from alcohol or prescription meds like Valium or Xanax. This can also be an indicator of methamphetamine or cocaine use, or can be a reasonable response to trauma or fear, head injury, or other illness or condition.

• Scratching or picking at one’s face can be a drug reaction (withdrawals from meth or cocaine, such as “coke bugs” or tactile hallucinations). These indicators can also be signs of scabies or lice, or can indicate nervousness, or an allergy.

References:


More On-Site Cues/Concerns

- People under the influence may be uncooperative, unwilling, or unable to provide useful information. Sometimes very little can be gained by trying to get an in-depth interview at this time.
- Be prepared to re-schedule if necessary.

Essential Learning:

People under the influence may be uncooperative, unwilling, or unable to provide useful information. Sometimes very little can be gained by trying to get an in-depth interview at this time. Be prepared to re-schedule if necessary.

**Trainer Guidance:**

Open up by asking the group, “How should we approach survivors in a trauma-informed manner and sensitively discuss personal substance use as a safety concern?” Generally speaking, if a survivor is using alcohol or other drugs, unless there is significant risk to health and safety, waiting until the person is not under the influence may be best time to discuss substance use in the context of safety. Don’t let the discussion be delayed for more than two shifts. If you don’t feel comfortable talking about it while you are alone, shift change can be a good time because someone would be available to back you up if necessary. It is useful to note observations of use and directly mention them to the person you are concerned about.

A sample way to deal with the obvious problem head on is as follows: “You have told me you have been under a lot of pressure during your stay. Anyone working as hard as you are will look for a way to feel better when feeling stressed. I’m concerned about you because I noticed alcohol on your breath this morning when you banged into the wall and bumped your head. Lots of people I see here drink for a lot of good reasons. I am concerned about you. How can I help you find a safer way to cope that will cause you less grief?”

**Essential Learning:**
• The important thing to do is to not ignore what you see, but to notice, to ask about it, and to be aware of patterns.

• It is also important to recognize when your own memories or feelings may be elicited and interfere with your ability to respond. It is okay to ask for help and to take your time.

• It engages the person to bring them into the discussion. Positively recognize that the survivor knows what is going on as well as you do. Expressing care and concern rather than being critical is most useful when helping a person face their own substance use.

• Be gentle. Survivors are often on the receiving end of unkind comments and criticism. Always include messages about the benefits of stopping use any time.

• Let the survivor know that if they have tried to stop in the past and could not do it safely, it is treatable when they are ready. If the survivor is afraid because they could not stop before, let them know you can refer them to others who can help when they want to stop.

References:


Trainer Guidance:

Slides 33-35 remind us why it is our ethical responsibility to provide services for survivors affected by a substance use disorder. We cannot let negative attitudes and beliefs about people who use substances interfere with our responsibility to work on behalf of survivors experiencing a substance use disorder or substance abuse coercion.

Open this series of slides by reminding participants, “The relationship between domestic violence/sexual assault and substance use (or misuse) is well documented and associated with increased lethality rates and greater severity of injuries for survivors.”

Essential Learning:

- Complex, intersecting issues such as a substance use disorder, trauma, mental illness, disability, or poverty can make it harder for a survivor to get safe from intimate partner violence or abuse. At the same time, inability to get safe or heal from intimate partner violence makes it harder for a survivor to address other issues (Edmund & Bland, 2011).

- It should be a standard of trauma-informed advocacy to routinely speak to ALL program participants about substance use issues in the context of domestic violence and sexual assault as part of a safety planning session.
Any survivor harmed while under the influence should be advised, “This is not your fault. The person who hurt you is 100% responsible for any abuse done to you whether you were drinking or using or not.”

**Discussion Questions:**

*Here are some questions advocates can practice before discussing substance use with survivors. They also can be used in a Focus Group with survivors.*

1. Can you think of any reason why it may not be safe to use when someone is trying to hurt you/stalk you/kill you?

2. How can your partner use your drinking or drug use to hurt you?

3. How has your partner used alcohol or other drugs to control/threaten/shame you?

4. When you have not been able to drink or use in the past, what helped you to cope?

5. Can you do that now?

6. If there is one thing I (or the group) can do to help you stay safe and sober today, what would that be?

7. What kinds of threats has your partner made about your substance use that are directed toward your parenting or housing?

8. What kind of threats has your partner made should you call the police, contact child protective services, or seek shelter, treatment, counseling, medical, or other forms of support?

**Handout:**

*Woman Abuse, Substance Abuse: What is the Relationship?*

**References:**


Juneau, AK: Alaska Network on Domestic Violence and Sexual Assault.
Harm Facing Survivors Using Alcohol and Other Drugs (cont.)

- Compulsive use/withdrawal symptoms may make it difficult to access shelter, advocacy, or other forms of help.
- A recovering survivor may find the stress of securing safety leads to relapse.
- If the survivor is using or has used in the past, they may not be believed.

**Essential Knowledge:**

- Alcohol and other drug use may be encouraged or forced by an abusive partner as a mechanism of control. Abstinence and recovery efforts may be sabotaged (IDHS, 2000).

- Survivors can sense if an advocate or allied professional judges them, looks down on them, or feels overwhelmed by their experience of a substance use disorder or substance abuse coercion. This may keep them from seeking and/or getting the help they need.
References:


The Wrong Questions

- Why don’t you just leave?
- Why don’t you just quit using?
- Why don’t you just pull yourself together?
- What’s wrong with you?

Trainer Guidance:

Open by stating: Trauma-informed service providers don’t ask, “What’s wrong with you?” Rather they explore the context of a survivor’s behavior to make sense of what has happened.

Essential Learning:

- Few things are more controversial than the use of labels. Some helping professionals are opposed to the use of any kind of label for any reason, while others consider labels a necessary evil. 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 (Edmund and Bland, 2008).

Optional Training Activity: (15-30 minutes)

Purpose: To help advocates and other providers recognize the plusses, minuses, and unintended results of labeling.
**Process:** Provide participants with the handout “To Label or Not to Label.” Have participants break into groups of 3-6 to read and discuss the handout together. Also provide each group with butcher paper and markers. Ask each group to select a recorder and reporter who will report back to the main group after the exercise is completed. During the review of the handout, group members should discuss how labels can be both hurtful and helpful. The recorder can list these pluses and minuses on the butcher paper. Additionally ask the group to identify strategies to resolve the issues of labeling with the people they serve. Have the recorder also list these strategies on the butcher paper. If time is limited, half of the room can address how labels can be hurtful and helpful. The other half can identify strategies to resolve issues associated with the experience of acquiring a label.

**Debrief:** After the discussion ask the group reporters to share what they have learned from each other with the whole room. If time is limited, 2 or 3 groups can be asked to report back rather than all of the groups. Sheets of butcher paper can also be posted around the room for training participants to review.

**Handouts:**

*To Label or Not to Label*

**References:**

Working with People Impacted by DV, Trauma, Substance Abuse, and other Psychiatric Disabilities

- A successful culturally competent intervention incorporates:
  - Awareness of one’s own biases, prejudices, and knowledge about the people we serve and their culture
  - Recognition of professional power (power differential between you and the program participant) in order to avoid imposing one’s own values on others

Slide 36: Working with People Impacted by DV, Trauma, Substance Abuse, and other Psychiatric Disabilities

Trainer Guidance:

Slide 36 begins this section of slides by helping us explore our work through a cultural lens. Two optional activities are provided. “Pair, Share, and Discuss” may work best with a small group if time is limited. The “I Pie” activity can be done in both a small or larger group setting and takes less time to process and debrief.

Essential Learning:

- A successful culturally competent intervention incorporates awareness of one’s own biases, prejudices, and knowledge about the people we serve and their culture.

- Cultural competency also involves recognition of professional power (power differential between you and the program participant) in order to avoid imposing one’s own values on others.

Optional Training Activities: “Pair, Share, and Discuss” or “I Pie” (Each exercise takes approximately 12-25 minutes depending on number of participants).

Purpose: Participants reflect on their own cultural identity and acknowledge who they
are and how their culture shapes internal identity as well as attitudes, beliefs and behavior – not just about themselves but about others. Cultural identity affects our external worldview and who we are, as well as how we relate to and interact with others. It also affects how we provide advocacy, counseling and other services. We can explore these concepts by using a written exercise: “Pair, Share, and Discuss” or, for visual learners, by drawing an “I Pie.”

**Process: Activity 1 – Pair, Share and Discuss:** Ask participants to make a list or write a paragraph focusing on their cultural heritage. Participants may choose to identify their country of origin, parents and grandparents’ nationalities, customs, language, favorite foods, holidays, role of religion, and education in their family, as well as ideas about sex roles, politics, music, or child rearing beliefs. What messages did they receive about dating, marriage, domestic violence, and substance abuse? Ask participants to break into pairs. Have each person share one to three things about their cultural heritage. Also ask a pair to share a message they received at home, school or church about dating, marriage, domestic violence, sexual assault, and substance abuse. After sharing, have the pair discuss similarities and differences.

**Debrief:** Have pairs report back on what they have learned from each other and how they think their cultural lens affects their ability to engage in relational service provision.

**Process: Activity 2 – Drawing an “I Pie”:** Provide blank paper and colored pencils. Ask participants to imagine they are a pie. Have them draw a large circle and then draw and label slices of pie, noting within each slice “who I am or what makes me, me.” There can be as many slices of pie as they like. Some slices may be small and others larger to illustrate what participants deem most meaningful in understanding themselves. **Note:** you may have to draw a slice to get participants started. This exercise allows participants to share their common bonds and value their differences.

**Debrief:** Have 1-3 people share pies by reading them or drawing them on a white or black board. Explore common themes and differences. Discuss ways the pies show how we are connected as well as how cultural diversity frames our identity, beliefs, and attitudes – thus affecting our ability to connect and relate well with others, as well as to establish trust.

**Handouts:**

*Working with Diversity*

**References:**

### Universal Screening and Identification for Better Accommodation

- Women experiencing psychiatric disabilities and/or substance use disorders may be at greater risk for injury and lethality.
- Universal discussion about this and other trauma impacting safety is an important tool for identifying barriers to safety and options.
- The best way to protect children is to ensure safety and recovery are possible for their non-offending parents.
- We can best support survivors seeking safety sobriety and wellness by reducing program service barriers and ending isolation.

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**Slide 37: Universal Screening and Identification for Better Accommodation**

**Trainer Guidance:**

Every day advocates work with survivors that other systems label as “impossible.” In our field, we understand survivors make decisions about their safety daily and we recognize dealing with domestic violence and sexual assault is a process. Remind participants, “As advocates, you have all the skills you need to support a survivor experiencing a substance use disorder or substance abuse coercion if you recognize the survivor you are working with is in a relationship with a substance whose chains are no less binding than the oppressive chains a batterer, offender, or person who hurts others, uses to bind and harm others.”

**Essential Learning:**

- Advocacy based counseling for those affected by mental health or substance abuse coercion and/or a substance use disorder or psychiatric disability may include: Repeating information, providing structure, simplifying goals, advocating for their inclusion in shelters and other victim service programs, and understanding the effects of substances on safety planning and your role as an advocate.

- Trauma-informed screening to accommodate addiction issues that may affect safety.
involves conveying the message that addiction and violence can happen to anyone: “Anyone in this situation is vulnerable. You are not alone should you be facing these problems.”

• A survivor’s decision to not stop using immediately or to decline treatment, advocacy, or shelter should not be viewed as failure. Like getting a protection order, seeking temporary shelter, or leaving for good, recovery is both an option and a process that can take time. Decisions about choices and timing belong to survivors. Listen to survivors and respect their decisions even if they differ from what you think is best. Know your resources. Build alliances with substance abuse prevention professionals and treatment providers so you will be ready to offer support when it is both needed and wanted.

**References:**

Slide 38: Initial Intervention and Follow-Up

**Trainer Guidance:**

Many batterers and offenders use mental health and/or substance abuse coercion to harm their partners. Countless opportunities to safety plan are missed when advocates are afraid to ask about substance use lest they offend, or if they view talking as futile. The intervention is in the asking. It is not necessary for advocates to become substance abuse treatment providers, but it is important for them to ask survivors about substance use in the context of safety to better accommodate their needs in the context of domestic violence/sexual assault.

Safety and sobriety are indeed possible. Acknowledging that the person before you has managed to survive, sincerely appreciating individual strengths, and recognizing innate dignity can support a survivor’s own process and help build a trauma-informed alliance that benefits survivors and their children. Keep in mind, survivors accessing services at domestic violence/sexual assault programs may feel more comfortable discussing another’s substance use rather than their own until trust is established. Chats about substance use should be held with everyone and held only after admittance. The chat should be within the context of safety, and focused on how to accommodate needs rather than deny services.
**Essential Learning:**

• Discussions about safety should include exploring risks associated with partner use, especially if mental health and/or substance abuse coercion is occurring. See the handout “Mental Health and Substance Abuse Coercion.”

• Sometimes a survivor may not be using or misusing substances, but their safety may be compromised by another’s use. Being forced to ride in a car with a driver who is under the influence, being forced to give rent or grocery money to someone who wants to score drugs, and being coerced into trading sex for drugs by an abuser are all forms of domestic violence.

• Follow-up during this conversation may include asking whether the survivor had to leave to come to shelter without meds, had meds stolen by an abuser, or was forced to use more than they wanted. Name this behavior as a form of domestic violence and ask if the survivor needs any assistance, advocacy or support. See the handout “Model Medication Policy for DV Shelters.”

• Once an initial discussion occurs, an advocate may believe a survivor has no significant problem with mental health, substance abuse and/or coercion or that the survivor may not be willing to discuss it yet. Should this be the case, general information about safety in the context of substance use can be explored and follow-up can be provided when the survivor feels more comfortable.

• The handout “Manifestations of Violence” can be provided to a survivor in a one-to-one or group session to help them identify issues related to substance use and domestic violence/sexual assault that affect safety.

**Handouts:**

*Manifestations of Violence.*

*Model Medication Policy for DV Shelters*

*Mental Health and Substance Abuse Coercion*

**References:**

Following a discussion, an advocate may discover that a survivor has an increased safety risk stemming from their, or another’s, significant problem with substance misuse or abuse. Sometimes a significant problem with substance abuse is not identified at an initial contact but is revealed later. Whenever substance abuse is identified, information about safety should be provided and concern should be expressed. Options should include reviewing safer alternatives to substance use, providing linkage to counseling and on-site support systems, as well as community-based referrals. Discussions about safety should explore risks associated with partner substance abuse as well as accompanying trauma.

While substance use and misuse are behaviors a substance use disorder (or addiction in lay terms) is considered a disability. Advocates should be familiar with the Americans with Disabilities Act and Fair Housing regulations. Have handout materials such as the chart above, and other tools available for anyone who might find them helpful.

Tia M. Holley, statewide training team member for the Alaska Network on Domestic Violence and Sexual Assault, created “Stages of Addiction, Stages of Untreated Trauma,” a “dip chart” or “Likert scale” to show the parallel paths that untreated trauma and untreated addictions follow. In early recovery feelings begin to emerge and emotional
numbing dissipates. If the multidimensional issues are not addressed concurrently there is a high risk of relapse because the emerging overwhelming emotions push the person back to the bottom of the vicious cycle. On the upside is how healing on multiple dimensions, (body, mind, spirit, and emotional levels), can help survivors get beyond the vicious cycle of pain.

**Essential Learning:**

- Domestic violence/sexual assault advocates and program personnel should have established relationships with substance abuse professionals, poison control, detoxification centers, emergency room and 911/EMT, and aid car personnel should a survivor experience a medical emergency (overdose, acute withdrawal, problems breathing, etc.) or other crises capable of causing grave injury or loss of life.

- It is allowed and recommended for advocates to seek immediate medical attention for someone experiencing an acute medical crisis related to substance use, especially if the survivor is unable to seek assistance (passed out, not breathing, experiencing seizure, etc.). Please follow your agency protocol.

**Handouts:**

*Stages of Addiction, Stages of Untreated Trauma* by Tia Holley

**References:**

Trainer Guidance:

Following admission during an interview to determine how to best accommodate a survivor, survivors may decide to reveal their recovery status from a substance use disorder and ask for support. Whenever information about the experience of a substance use disorder is shared with us, information about safety should be provided and concern should be expressed about risks to sobriety associated with domestic violence and stress. These concerns may be greater for survivors with less time in recovery, but also very real for any survivor addressing both issues regardless of amount of time in recovery.

Trainers should emphasize: "Discussions about the survivor’s experience of a substance use disorder should NOT be routinely documented in the survivor’s chart."

Essential Learning:

- Basic safety and sobriety tips should be available on site, as well as information about risks associated with a partner’s substance use. Options should include reviewing current support systems, providing linkage to counseling and on-site support systems, as well as community-based referrals.
• A wealth of handouts designed to support safety and sobriety are available from *Real Tools: Responding to Multi-Abuse Trauma*, published by the Alaska Network on Domestic Violence and Sexual Assault and available as a “click and print” version on their web site. See below for some particularly good handouts that can be shared with survivors desiring support, or follow this link: [http://www.andvs.org/realtoolsprint/](http://www.andvs.org/realtoolsprint/).

• If asked for, follow-up is indicated periodically to determine whether increased support is wanted. The experience of a substance use disorder often includes periodic relapse.

• Many survivors ask for support in advance as part of an accommodation plan should obvious signs of renewed preoccupation with substances or substance use occur. If the survivor has asked for this kind of support, it is important to address any concerns immediately in the context of safety.

**Discussion Questions:**

1. What resources exist in our community for survivors who want support for their recovery?

2. What can we do in our own organization to support survivors seeking recovery from substance abuse/addiction?

**Handouts:**

*Women Abuse/Substance Abuse: What is the relationship?*

*Merry go rounds of addiction and violence, with instructions*

*Ending Isolation: Reducing Anxiety Through Connection*

*Safety at Support Group Meetings*

*Using 12 step groups*

*Mini Safety/Sobriety/Wellness Plan*

**References:**

Discussing Domestic Violence or Substance Abuse

- Conversations must be respectful, private, and confidential
- Children should not be present
- Communication should be age and developmentally appropriate, as well as culturally relevant
- Use an interpreter when necessary

**Trainer Guidance:**

Be sure to remind training participants, “You are not asked to cure or fix domestic violence/sexual assault or substance use disorders/addiction.”

Say also, “Rather, if you are concerned a survivor has an increased safety risk stemming from their personal use, or someone else’s significant problem with substance use, options should include reviewing safer alternatives to substance use, providing linkage to counseling and on-site support systems, as well as community-based referrals. Discuss safety options including support groups and treatment as an option *not a requirement for services* with an open, supportive and non-judgmental attitude.”

**Essential Learning:**

- Domestic violence/sexual assault and substance use disorders/addictions are long-term problems that require complex solutions.

- The safety intervention occurs in the context of the relationship between advocate and program participant, which often begins in a conversation about how we can best accommodate a program participant’s needs.
• This conversation to insure welcoming and accessible services is your opportunity to counter any negative messages as well as offer program accommodations.

• Program accommodations may include reminders, safety plans in the context of substance use or abuse, appropriate referrals to your local substance abuse professional, or whatever else is needed to support safety and comfort.

**Handouts:**

*Emotional Well-Being: Sample Questions to Ensure Better Accommodation*

*Follow-up Questions to Enhance Service Provision for All*

*Where Can I Get Help?*

**References:**

Discussion about DV, trauma, substance abuse or mental health may lead to concerns about co-occurrence.

Survivors may find it easier to talk about stress in their relationships or their partner’s substance use or symptoms before talking about DV or their own use, etc.

They may also be willing to discuss concerns about their children.

To better accommodate survivors experiencing an active substance use disorder, expressing care and concern rather than being critical is most useful when helping them address their substance use and its impact of their safety. Be gentle. Always include messages linking safety and sobriety and address the benefits of stopping use any time. This problem affects sufferers whether they are actively using or not. A substance use disorder is marked by physiological and central nervous system changes that can be challenging to manage (Edmund & Bland, 2011).

Inform advocates that they will need to help survivors assess whether the immediate risks from a batterer (offender or person who hurts others) outweigh those stemming from their current substance use or substance use disorder, or vice versa. Ultimately this is not a question of whether safety or sobriety should take place first. Safety and sobriety are both important options, since one is less likely without the other. Rather, the question is: What does the survivor want to talk about today?
• Always begin conversation by describing how batterers use substances against the people they hurt. Explore whether this type of harm has happened.

• Reassure survivors that any harm done to them is not their fault. Offer hope and practical support.

• Discuss available options and strategies to provide accommodation including options to support behavior change such as 12-step programs, substance use/domestic violence/sexual assault support groups, and treatment options.

• If possible, suggest a referral for a more in-depth assessment with a treatment provider and make the appointment together if the survivor is interested. If the survivor requests it, get a release of information and maintain communication with the treatment provider to support the survivor’s progress.

• Be sure to follow up and provide emotional support. Some survivors may be unwilling to address their active use at this time so safety planning including a variety of options may need to be explored.

**Handouts:**

*Performing a Needs Assessment*

*How Do We Ask Those “Sticky” Questions?*

*Safety Plan (Includes planning for safety when substance use/abuse is involved)*

**References:**


Slide 43: Substance Use, Trauma, and Psychiatric Symptoms May Affect Memory

**Trainer Guidance:**

The material in this slide is similar to information in Slide 16; however, blackout and memory deficits are often challenging for participants and this piece can re-enforce prior learning plus serve as an opportunity to review safety connections and address issues about batterer accountability. The Trainer can also point out that a psychiatric disability (i.e. dissociation), trauma, head injury and strangulation can also affect the brain, and therefore the memory, as well as thinking and processing.

Survivors may have a hard time recognizing options or gauging safety. Some survivors may experience blackouts. People in a blackout state may appear to be functioning normally but later have no memory of what occurred while under the influence (Kinney & Leaton, 1991). Safety planning problems can include being unable to recall a safety strategy, not knowing how an injury was sustained, and failing to remember making a police report, let alone remembering a court date.

While blackouts impact memory, there is no evidence to support the contention that a blackout alters judgment or behavior at the time of its occurrence (Kinney & Leaton, 1991). Thus, batterers cannot be excused for their behavior when they are under the influence merely because they cannot remember it. Batterers may misuse euphoric recall and blackouts to minimize, rationalize, or deny their abusive behavior.
Essential Learning:

- Advocates must consistently give the message that using substances as an excuse for violence is not acceptable. Collusion with this erroneous belief helps a batterer avoid accountability for abusive actions and mistakenly encourages a survivor to believe that once the substance abuse ceases the violence will automatically stop.

- Safety planning includes finding out what happens when a person is using, not using, trying to get help, or is being coerced into using.

- Questions about the offender’s use are key. Is risk worse when the offender is using, hung over, or craving a substance and can’t get it? What can you do to get safe? What have you done in the past? What would you like to try now? How can we help you?

- Always reassure and validate a survivor.

Handout:

"Safety Concerns: Memory Deficits and Physical Harm"

References:

Sample Framing Questions for Substance Abuse

- Survivors I see often tell me they feel stress. There are several ways to deal with stress. What works best for you?
- Many survivors tell me they try to sleep more, eat better, or shop for baby things. Have you tried any of those ways of coping?
- Many survivors also tell me the best way to cope is to smoke a cigarette, have a drink, or take something else. How often has that worked for you? Do you find it is still working?

**Trainer Guidance:**

Remind participants that substance use is a coping mechanism anyone might use. It is okay to ask about coping in the context of a safety plan with the survivors we work with.

The Trainer may want to begin by advising participants to explore how survivors cope. People don’t generally respond well to questions like, “Do you drink or use drugs?” Most people are afraid to reveal this information lest they be denied services, be asked to leave, or be criticized, judged, or blamed. They may be worried they will be labeled as a bad person or a bad parent and might be terrified they will be reported to child protection services.

You want to discuss substance use in the context of domestic violence/sexual assault and normalize how anyone experiencing the trauma of domestic violence or sexual assault may have experienced substance abuse coercion or have chosen to use substances to cope.

**Essential Knowledge:**

Rather than telling people what to do, when talking about coping in the context of domestic violence/sexual assault and substance abuse, exploring the following safety
concerns with survivors may be useful:

- What might make you think using substances now might not be the safest coping tool?

- What have you done to manage when alcohol or other substances were not an option or not available?

- A lot of people tell us they want to stop but are too overwhelmed. That is normal. If you find yourself in that situation there is a lot of help available. I am a safe person to talk to about your options.

- You are in charge of how much information you share or how much you don’t, but if you are concerned about anything to do with domestic violence/sexual assault and alcohol or drugs, I have learned a lot from other survivors and can help you think your options through.

- If alcohol and drugs are no longer working we can explore what will help rather than hurt you.

- If your partner is using your alcohol or other drug use to threaten, control, or intimidate you, we can help you safety plan.

**Discussion Questions:**

1. How comfortable are you discussing a survivor’s personal substance use in the context of coping with domestic violence/sexual assault?

2. Are there other ways of talking about substance use in the context of safety that would work better for you?

3. Have you tried discussing substance use in the context of safety before?

4. What happened?

5. What do you think might make it easier or more comfortable for both you and the people you are working with to discuss substance use in the context of a safety plan?

**References:**

Sample Screening Questions if Partner is User or Abuser

- Many survivors tell me their partners don’t want to drink/drug/smoke alone. How often do you find yourself using when you don’t really want to?
- When a partner spends family money on drug use, it is a form of economic abuse. Has your partner ever used food or rent money to drink or score drugs?

Trainer Guidance:

Many survivors find it easier to discuss their partner’s substance use as opposed to their own. This is particularly true of women in abusive relationships whose abusers drink or use drugs.

Essential Learning:

- A conversation about an abusive partner’s substance abuse gives one the opportunity to explore a survivor’s history of substance use in the context of coping as well as a mechanism of power and control, either or both of which can be affecting safety.

- When a survivor discloses a history of domestic violence or substance abuse on the part of a partner, offer a supportive statement such as: “It must be hard for you to believe someone who started out so nice could become so hurtful.”

- One can also say the same about substances: “It must be hard to believe something once so helpful now is causing trouble.”

- Then validate the fact the person you are talking to has survived and praise the survivor sincerely for finding a way to cope. “You deserve credit for doing the best you
can in these circumstances.”

• Later you can follow up with, “There may be some safer ways of coping that may cause you less grief if you want to talk about it.”

• The handout “Power and Control Model for Women’s Substance Abuse” by Marie T. O’Neil may be helpful when addressing either the partner’s substance use/abuse or the survivor’s.

• However, remember these tools are best used for self-assessment and should not be placed in a program participant’s files.

**Handouts:**

_The Power and Control Model for Women’s Substance Abuse by Marie T. O’Neil_

**Assessing Needs**

**References:**


Substance Abuse Screening for Accommodation

- Discussing partner use may be easier initially
- People may be afraid to tell you the truth
- Assume use occurs until you determine differently
- Don’t ask, “Do you...?”
- **Do ask,** “When you...?”
  - Inflate amounts. Listen for responses indicating further risk assessment, program accommodations, or safety planning may be needed. Offer options and resources for consideration.

**Slide 46: Substance Abuse Screening for Accommodation**

**Trainer Guidance:**

Trauma-informed risk assessment of the impact of substance use/abuse on safety is an opportunity to sow seeds that can ultimately reap increased safety, recovery, and better health outcomes for survivors and their children. The opportunity to safety plan and develop program accommodations again, occur when conversations about these issues are universal and nonjudgmental---in other words we talk to everyone we see about how substance use effects safety and safety planning, how substance use can be a coping tool that can lead to problems, and how substances and substance use can be used by a batterer to gain or maintain power and control.

Trainers should stress that this discussion should be had after admittance and not as a reason to deny access to services. Encourage participants to assume the survivor uses something unless they learn differently. Most people use alcohol or other drugs at times, whether for social or medical reasons. People who do not use generally do so for one (or more) of the following reasons: cultural or religious reasons, health reasons, including recovery from a substance use disorder, or because they are a family member of person with a substance use disorder who has determined never to use based on that experience. The latter is called “the skip phenomena,” and is sometimes a choice made by children whose parents have a substance use disorder.
Some people experience a substance use disorder. Substance use as well as a substance use disorder can be used against a survivor in the context of domestic violence and/or sexual assault, which is why we talk about these experiences in the context of safety planning.

**Essential Learning:**

- When discussing substance use, do not grill the survivor you are talking with.

- After you have gently explored concerns about the partner’s use, you might say, “When I hear a partner is drinking or using I often hear they don’t like doing it alone. What do you generally like best, beer, wine, or something else?” If the person generally does not use, they will tell you so now.

- If they do use, they will generally identify the drink or sometimes the drug of choice. Once they do, let’s say the person says, “beer,” you can ask, “What’s normal at your house...a six pack a day or a case?” Most people are delighted to tell you how much less they are using and you can move into safety concerns and ask: “Do you ever find your partner makes you use more than you like? Has your partner criticized you for not drinking or for drinking too much?”

- Then ask how they think a partner might use substances against them.

**Handouts:**

*The Power and Control Model for Women’s Substance Abuse*

*Assessing Needs*

**References:**

Sample Framing Questions for Substance Abuse

- Being involved in a custody dispute can be stressful. Your partner may attempt to undermine your parenting skills. Can you identify any reasons why drinking or using drugs right now could be harmful to your case? Can you share with me what your partner might say about your drinking or drug use?

Trainer Guidance:

Trauma-informed service providers and advocates recognize survivors experiencing a substance use disorder and/or substance abuse coercion are often met with hostility from other systems and service providers.

Additionally these issues can pose risks for children as well. Custody concerns are critical and all program participants should be offered an opportunity to explore how an abusive partner may try to use a survivor’s substance use to cause harm as well as how to support children affected by exposure to both domestic violence and substance abuse issues.

Essential Learning:

- Advocates may want to start with: “It is perfectly normal for an adult to want to have a drink. However, during the next few weeks, can you think of any reasons why drinking or using may not be in your best interest/your safest choice/problematic?”

- If the survivor has some reasons, a follow-up question might be: “Have you ever taken a break from drinking/using? What happened? How easy or hard was it to get through the day?”
• Discuss possible custody concerns: “Abusers often threaten to turn their partners in to child welfare or tell them they are a bad parent. Sometimes during child custody fights, it is a good idea to stop using or to cut back considerably. How hard would that be for you? If you decide having a drink or using is okay, are you worried your partner will try to get the children to talk about it? What plan do you have in place to keep both you and your kids safe from the abuser if the abuser is drinking or using or makes you use against your will?”

• Conclude with, “Sometimes people feel like taking a break from drinking or using but find it is more of a struggle than they expected. What kind of support will you need if you decide not to use? Some people decide to stop using and find they can’t – that happens a lot. If it ever happens to you, I am a safe person to talk to about this. Don’t worry, help is always available in some form.”

Optional Training Activity (10-15 minutes)

Purpose: To consider the impact of domestic violence and substance abuse on children and the importance of safety planning that includes the safety needs of children.

Discuss: Have participants break into groups of 3-6 to read and discuss handouts together. Provide each group with butcher paper and markers. Ask each group to select a recorder and reporter who will report back to the main group. During the review of the materials, group members should identify additional safety planning strategies they have used in their work with survivors and their children. Also ask the group to discuss ways to foster trust, create a welcoming environment and talk to parents and their children about substance abuse and DV from their personal experience.

Debrief: After the discussion, ask the group reporters to share what they have learned from each other with the whole room.

Handouts:

Safety Planning Interventions for Children

Children Affected by Domestic Violence and Substance Abuse

References:

Talking about Safety and Sobriety

“Can you think of any reasons why drinking or using substances might not be the safest option right now?”
“How might your partner use your substance use against you?”
“If there is one thing I can do for you today what would that be?”

Trainer Guidance:
Continue the conversation started in the previous slides. Review slide questions above with the group and brainstorm what else might be useful to talk over with survivors.

Essential Learning:
• As advocates, we should always try to discuss substance use in the context of domestic violence/sexual assault. Survivors are often willing to discuss these issues when they are met with a trauma-informed response that acknowledges what has happened to them rather than what is wrong with them.

• Over time, one finds the above questions are useful whether discussed 1-1 or in a group. These questions provide a framework for survivors to use their own critical thinking skills as well as offer survivors an opportunity to ask for what they need in terms of program accommodation.

Note: Information about substance use such as the answers to the questions we have just explored should NOT be written in program participant files.

Discussion Questions:
1. What else might be useful to discuss with survivors in addition to the questions posed in these slides?

**References:**

What do I do if they say, “Yes” about Substance Abuse, Trauma, and Domestic Violence?

- Safety plan
- Include options:
  - Support groups
  - Programs addressing DV, Substance Abuse, Trauma, and Mental Health
    - When appropriate offer option of referral to gender specific treatment
- But before you do any of this…

**Trainer Guidance:**

Before briefly reviewing the points on the slide, begin by saying, “Perhaps this slide or overhead should read, ‘What do I do if a survivor says no?’”

“No” is a very common response to whether or not domestic violence, sexual assault, substance use, trauma, or other psychiatric disability is present.

A negative response to whether substance use poses a safety risk is an opportunity to review the benefits of abstinence from substance use as part of a safety plan.

**Essential Learning:**

It is most important to let survivors know you talk about substance use in the context of safety with everyone. Also, let survivors know they can always talk to you or a colleague should their situation change. Here are some possible things you might say:

- “I am glad to hear there are no concerns about abuse or substance abuse now. Should that ever change, this is a safe place to talk about domestic violence, sexual assault, or substance use.”
• “I am glad all is well for you. This week we are asking all survivors about safety at home here.” OR, “This week we are asking all survivors about their coping skills. Because domestic violence and substance use are such common experiences, we are talking to everyone we see. You may have a friend who might find this information useful, even if it does not directly apply to you right now.”

• “Sometimes people don’t know help is available. Since we have brought up the topic, feel free to take a brochure or leave it here until the next time you come. You may not need it, but we offer them to everybody just the same as a resource for friends and family.

• “Up to 95% of women in substance abuse treatment report some kind of abuse history, whether it be in the distant past or in the present. This is a safe place to talk about domestic violence, sexual assault, substance abuse, or other things worrying you. Let us know later if you should recall anything that concerns you.”

References:

Validate

- No one has the right to hurt you. You did not deserve this.
- It is never your fault when someone harms you even if you were drinking, or using, or off your meds. You did not cause this to happen! An abuser chose to be violent.
- I’m so glad you found a way to survive.
- Drinking or drugging can kill pain for a while but there are safer ways of coping that can cause you less grief.
- You deserve a lot of credit for finding the strength to talk about this. Your safety can improve your children’s safety and well being, too.

Slide 50: Validate

Trainer Guidance:

Advise participants that the messages in this slide are the most important element of the training. If the only thing we can do is to communicate these messages to a survivor, then we have done plenty.

Review the positive, validating statements above with participants. Brainstorm and ask the participants if they have other positive messages they have shared with survivors.

Essential Learning:

- Trauma-Informed advocacy includes reminding people of their human rights, and validating what has happened to them.

- Advocates affirm survivors and acknowledge the experience of domestic violence, sexual assault, substance abuse coercion, or the experience of a substance use disorder is not their fault.

Discussion Questions:
1. In addition to the messages on this slide (or overhead), what other positive messages have you shared with survivors?

References:

ABC’s of Advocacy Based Counseling

- Acknowledge harm has been done. Avoid re-victimizing
  - “Abuse is never your fault. Your safety is important.”
  - Active abuse is traumatic and painful. People do their best to survive. “You deserve credit for surviving.”
- Offer options to make coping and surviving safer

Slide 51: ABC’s of Advocacy Based Counseling

Trainer Guidance:

Slide 51 is a continuation of slide 50. Review basics of Advocacy-Based Counseling (ABC) listed on the slide with participants.

Essential Learning:

- Trauma-informed advocates sincerely acknowledge and respect the ability of survivors to survive despite all the harm they have experienced.
- Always take time to validate everyone you see whenever you can. Your message of support may be the only positive words a survivor has heard from anyone for a long time, if ever.
- Along with validating it is also important to offer safety options.

References:

Slide 52: Expanding Our Safety Planning

**Trainer Guidance:**

Trainers may want to share the following with the group: “Results of a national epidemiological study found women whose partners have alcohol problems were more likely to experience interpersonal violence, or to experience multiple injuries (as compared to women with partners without alcohol problems). Women whose partners had alcohol problems experienced two to three times the odds of victimization, multiple injuries, mood and anxiety disorders, and fair or poor health compared with women whose partners did not have alcohol problems” (Dawson, Grant, Chou & Stinson, 2007)

**Essential Knowledge:**

- Remember, safety and sobriety plans may need to be adjusted and fine-tuned as a survivor’s situation changes. Safety planning is a process and as domestic violence and substance abuse – or recovery – progress, safety and recovery needs often change.

**Discussion Questions:**

1. *How might a survivor’s safety needs change as their situation changes?*
References:


Mini-Safety/Sobriety/Wellness Plan

- **Strategize:** Steps to reduce risk/use/harm
- **Develop:** Options to keep safe/sober/well
- **Identify:** Trusted allies/safe sponsors/strengths
- **Plan:** Means to escape abuser/drugs/unhealthy coping tools
- **Discuss:** Referral resources
- **Avoid:** Danger/persons, places, things/health risks
- **Tools:** HALT/One-day-at-a-time/Follow-up

Caution: Written materials, referrals can place survivors in danger

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**Slide 53: Mini-Safety/Sobriety/Wellness Plan**

**Trainer Guidance:**

Trainer should review components of a Mini-Safety-Sobriety-Wellness plan. After reviewing the material, be sure to pass out a copy of the instructions for the plan. Encourage participants when they are working with survivors to never print safety plans on both sides of a piece of paper so survivors can write their own unique adaptations on the back.

Most of the Essential Learning is provided on the handout and accompanying instructions. An Optional Training Activity is included here as well.

**Essential Learning:**

Some survivors who have not experienced alcohol and other drug treatment or peer support for a substance use disorder may be unfamiliar with some of the tools such as HALT. Survivors of both domestic violence/sexual assault and a substance use disorder have shared concepts such as HALT *(being aware of risks for relapse when you are hungry, angry, lonely, or tired)*, as well as dealing with both safety and sobriety issues “one day at a time,” helps them to avoid being overwhelmed as well as to stay safe.
Optional Training Activity: (20 - 30 minutes)

**Purpose:** This exercise is designed to provide practice for participants seeking to develop safety-planning skills. Participants are provided an opportunity to practice and/or observe each other listening, validating, and offering survivor-defined assistance.

**Process:** Split the participants into 3 or more groups of four. Have each group designate roles of a survivor, an advocate, an observer, and a reporter. The survivor will tell the advocate a little bit about their situation. The advocate will listen, validate the survivor and ask, “What have you done to keep safe up until now?” The advocate can listen to the survivor, and explore if the current plan is still working. The survivor can let the advocate know what they would like to try next if it seems safe for them to share. The advocate and survivor can review the Mini-Sobriety-Safety Plan together. The observer will record what happens during this conversation between the survivor and the advocate. The reporter will report the observations back to the entire group following the exercise.

*Note: If more than 4 people are in a group, the extras can take turns responding as the advocate or taking notes as an observer. The person playing the role of advocate and the survivor can ask for help from others in the group to help the survivor and advocate work together to develop a safety plan. The survivor can share as much or as little info as feels comfortable.*

**Debrief:** After the exercise the observer and reporter can ask each participant how it felt playing the roles: What worked best? What would they do differently? What was most challenging? The reporter can share with the group at large what happened. If the class is large, the Trainer can select one to three reporters from around the room to report back on their group’s experience at the end of the activity. The Trainer can wrap up by asking the rest of the room, “Is there anyone else who has something to share before we move on?” before summarizing key points and concluding the activity.

**Handouts:**

*Mini Safety/Sobriety/Wellness Plan*

*Instructions for a Mini-Safety Plan*

*Safety Plan (Includes planning for safety when substance use/abuse is involved)*

**References:**

Partnerships for Safety, Sobriety, and Wellness

- Address the impact of substance abuse, trauma, and mental health on safety, and DV on recovery and wellness.
- Develop integrated tools for screening and referral
  - Provide integrated training on domestic violence, sexual assault, trauma, mental health, and substance use, abuse, and dependence

Slide 54: Partnerships for Safety, Sobriety and Wellness

Trainer Guidance:

The Trainer can begin this series of slides by reminding participants they are not alone. Begin by saying, “You are not alone. Make sure you know where to turn for help. Seek consultation from your local substance abuse treatment professional or the National Center on Domestic Violence, Trauma & Mental Health.”

Essential Knowledge:

- Developing a working relationship with substance abuse counselors and other professionals in the community is an important part of your effort to support survivors with co-occurring issues. Establishing relationships with a variety of other providers can help all of us provide more and better services.

- The National Center on Domestic Violence, Trauma & Mental Health provides many training tools, protocols and tip sheets to help you do your work. For more information feel free to visit their website: [http://www.nationalcenterdvtraumamh.org/](http://www.nationalcenterdvtraumamh.org/). See also their series of webinars on domestic violence/sexual assault and substance abuse to supplement your training efforts: [http://www.nationalcenterdvtraumamh.org/trainingta/webinars-seminars/](http://www.nationalcenterdvtraumamh.org/trainingta/webinars-seminars/)
Discussion Questions:

1. What kind of partnerships have we developed with other providers in our community?

2. How can we do better in this area?

Handouts:

Advantages of Working with Other Providers

Creating Alliances
Avoid Re-victimizing

- People do not choose to develop psychiatric disabilities or substance use disorders any more than they pick out batterers
- Think before speaking. How would you like to be spoken to?
- Remember to offer respect, not rescue; options, not orders; safe treatment rather than re-victimization

Slide 55: Avoid Re-victimizing

Trainer Guidance:

Encourage training participants to add *Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror*, by Judith Herman to their library. While this book does not spend a lot of time addressing substance abuse issues directly, it is extremely helpful. Tell participants, “If you only have time to read one book right now, make it this one.”

*Trauma and Recovery* brings a new level of understanding to a set of problems usually considered individually. Herman draws on her own cutting-edge research on domestic violence, as well as on a vast literature of combat veterans and victims of political terror, to show the parallels between private terrors such as rape, and public traumas such as terrorism. The book puts individual experience in a broader political frame, arguing that psychological trauma can be understood only in a social context. Available at bookstores, or order from amazon.com.

Essential Learning:

- Trauma-Informed advocacy is about empowerment. Survivors are more likely to benefit from our services if they feel safe, are able to share their stories and feel a sense of connection.
• This connection is not just between an advocate and a survivor, but also to others who can share their experience, strength, and hope, and offer support in a trustworthy, trauma-informed way.

References:

Herman, J.L. (1997). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror*. New York: Basic Books.
For Survivors Experiencing DV/SA, Trauma, and Substance Use Disorder, Safety Planning Includes:

- Developing a relapse prevention plan, continuing connection, and support after relapse for survivors choosing to continue to work on their safety and recovery
- Linking to a range of DV/SA and substance use assistance options, such as medical detox, inpatient or outpatient treatment, advocacy based counseling, shelter, 12 Step meetings, and other peer support groups, etc.
- Providing relevant written materials

**Slide 56: For Survivors Experiencing DV/SA, Trauma, and Substance Abuse Disorder, Safety Planning Includes:**

**Trainer Guidance:**

Remind training participants again: “You are not alone. Make sure you know where to turn for help locally as well as from the National Center on Domestic Violence, Trauma & Mental Health. Make a commitment today to contact other agencies to begin or deepen a relationship committed to better service provision for the survivors we serve.”

The Optional Training Activity below encourages participants to start thinking about ways they can support survivors by collaborating with substance abuse counselors and other professionals in the community.

**Essential Knowledge:**

- The National Center on Domestic Violence, Trauma & Mental Health provides many training tools, including a series of 8 webinars on the intersection among domestic violence/sexual assault, trauma and substance use. Protocols, tip sheets, a special collection of resources and access to literature reviews are available to help you do your work. For more information feel free to visit their website: [http://www.nationalcenterdvtraumamh.org/](http://www.nationalcenterdvtraumamh.org/).

- A wealth of handouts designed to support safety and sobriety are available from *Real Tools: Responding to Multi-Abuse Trauma*, published by the Alaska Network on Domestic
Violence and Sexual Assault and available as a “click and print” version on their web site. Follow this link: http://www.andvsa.org/realtoolsprint/.

Optional Training Activity – Next Steps in Your Home Community: (15-20 minutes each)

**Purpose:** Encourage interdisciplinary opportunities and engage in critical cross-disciplinary thinking.

**Process:** Encourage participants to invite their community partners to work together on a Sample Case Scenario and talk about some of the “optional discussion questions” at the end of each scenario. Both Discussion Questions and Scenarios are provided with this training module. (See handouts below.) These can be quite useful for small group interdisciplinary activities or for providing inter- and intra-disciplinary training. These tools can help advocates and allied providers clarify options, practice skills, and develop confidence.

Case scenarios, like discussion questions, are useful for practical learning and assist in the development of critical thinking. Case scenarios can help participants move from theory to practice and facilitate the transfer of knowledge by helping participants build on existing skills and strengths.

The sample case scenarios provided with this module are adapted from the Alaska Network on Domestic Violence and Sexual Assault Training Curriculum and may be used with or without the accompanying series of questions. After reading the scenarios, group members can answer the questions and discuss their responses with the group. The accompanying questions are designed to expand cases and explore a variety of themes for providing culturally relevant domestic violence identification and intervention. Scenarios can take 10-15 minutes each (or longer) to read and respond to, depending on level of detail sought and amount of time available. They are ideal for a brown bag lunch session.

**Trainer Tip:** Trainers should be aware that sample case scenarios are not without pitfalls. Participants may feel the case is too easy, not reflective of what they do, or too complex. Case scenarios can also be upsetting, triggering, and overwhelming to participants. Encourage and make space for people to take breaks if they need to.

**Debrief:** Explore what worked, what was relevant, and what might be useful for your next interdisciplinary get-together. It can be very useful to ask participants to discuss a current case they are working on (without including identifying information) or to get examples of challenging cases directly from the group or agency prior to the next training or brown bag lunch. Encourage people attending your training activity to help develop sample case scenarios specific to the diverse training needs of your own community and schedule your next session!

**Handouts (Sample Case Scenarios):**

*Vanessa: Excerpts from a "Family Support" Intake Interview*

*Sheila’s Story: A Struggle with Violence and Addiction*
**Escaping**

- Survivors with multiple, complex problems can find safety and recovery options
- People address multiple abuse issues when it is safe to do so
- Offer supportive options for those seeking safety, sobriety, and wellness

**Slide 57: Escaping**

**Trainer Guidance:**
Remind participants to be hopeful.

**Essential Knowledge:**
- Safety, sobriety, and wellness can occur. It helps when we believe this and believe in the people we serve.
- See handout below for an inspiring interview with 10 women who have been successful in achieving both safety and sobriety. These successes do happen!

**Handouts:**
*Women Talk about Substance Abuse and Violence*

**References:**
“They were right there for me”

“They were right there for me.” Somebody wanted to show me support, listen to me, not yell at me, not scream at me, just look at some options instead of that. Through them showing love to me, I began to love myself. I didn’t deserve the punishment for all that had happened in my life. The continuous bad relationships, continuous abusing the drugs, and shame and the guilt I felt from all that. I deserved better. It was also OK to heal from all that.”

Slide 58: “They were right there for me”

Trainer Guidance:
Remind participants our work is rooted in the experience of survivors. Read, or ask a participant to read, the words a survivor shared on slide 58.

Essential Learning:
Listen to survivors. Your open heart is the most precious gift you have to offer.

Discussion Question:
1. What experiences have convinced you that your work is worthwhile?
Forging Partnerships:

Integrated Stages of Social Change

- Assessing Substance Abuse & Mental Health in context of DV/SA coercion & safety
- Information and Education
- Advocacy based counseling, consider link with counselor
- 1-1 and Group
- Practical non-judgmental options and support
- Referral and Linkage
- Safety linked with sobriety and wellness
- Social Change Model
- Screening for Domestic and Sexual Violence as barriers to treatment and recovery outcomes
- Information and Education
- Solution Based Counseling, consider link with advocate
- 1-1 and Group
- Practical non-judgmental options and support
- Referral and Linkage
- Sobriety and wellness linked with safety
- Social Change Model

Slide 59: Forging Partnerships

Trainer Guidance:

Collaboration with substance abuse professionals, survivors including people in recovery, as well as professionals and peers from other helping systems is critical. This slide describes many steps that are helpful for program participants.

The slide above has the info split into two sections when you look at it on screen. Have an advocate read what can be done in a domestic violence program, and a substance abuse treatment provider (or other behavioral health provider) read what can be done in a treatment setting.

Essential Knowledge:

- The key points listed on the slide above are the elements that are useful to recap.

- Even when priorities and philosophies are different, this doesn’t mean advocates must compromise our own standards to work effectively with other providers. Nor is it necessary for other providers to compromise their standards or priorities to work effectively with us. See handout “Types of Providers, Their Philosophies, and Priorities” for suggestions on creating collaborative relationships with substance abuse counselors and with other community providers.
Handouts:

*Types of Providers, Their Philosophies, and Priorities*

References:

Slide 60: Community Partners

Trainer Guidance:

Encourage participants to form relationships with each other across disciplines. Recommend programs, and consider having staff members get together for quarterly brown bag lunches or other opportunities to learn from each other about their services, fields, or concerns.

Provide participants with a stamped post card and ask them to address it to themselves. Ask them to remind themselves of what steps they will take to connect with a community partner and what date they will do it by. After they pass the postcard back to you, mail it in 7-10 days as a reminder.

Close by thanking participants for attending this training as well as for the hard work they do.

Final Note:

Also remember, the training you provide today is the least important part of your work. It is much more important to develop a relationship with the participants, encourage them to contact you if they need help, provide on-going technical assistance, offer additional resources or just be available to occasionally debrief. This means more to people than a stand-along training.
The people you are training today are the future. Be on the lookout for people you can mentor and guide and rely on to help you develop more accessible and sustainable programming and options for the people we serve as well as to help you develop advanced training in the future.

And finally, thank you. Thank you caring about the service needs of survivors experiencing substance use coercion and a substance use disorder. Also, thank you for being willing to tackle this topic and for all your hard work preparing and delivering this material. Take time to debrief, enjoy life, and know you have provided a very important service for survivors!

>All the best, Patti Bland and Debi Edmund.
References
References


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Downs, W.R., Department of Social Work, University of Northern Iowa. Personal communication with Patricia Bland, April 2002.


Herman, J.L. (1997). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror*. New York: Basic Books.


O’Neil, M.T. (1996). *A power and control model for women’s substance abuse.* Adapted from: Domestic Abuse Intervention Project, Duluth, MN.


Role Plays and Scenarios
Note Regarding Role Plays and Scenarios:

The role plays and scenarios provided here are based on the composite experiences of many survivors. As such, their stories can elicit feelings and emotions that may cause some discomfort for participants. Feel free to change details or shorten materials as needed to make these sample role plays and scenarios more reflective of your local community.

It is often a good idea to have the class take a brief break before starting a role play or case scenario training activity. Remind participants that sometimes exercises like this can be challenging and that if anyone wants to opt out they can do so at their discretion. It is important to debrief after the role plays and remind participants who is available to provide training participant support if further debriefing is needed.
Excerpts from a “Family Support” Intake Interview
From a Substance Abuse Treatment Program

When Vanessa was a young girl, her mother frequently asked her to go “get cigarettes” from her mother’s boyfriend. When she was ten years old, Vanessa’s brother told her that she was really getting drugs for their mother and showed her the small plastic package in the back of the cigarette case. Vanessa no longer wanted to go on these errands, but her mother said she would not cook for Vanessa if she did not. Vanessa’s mother is addicted to heroin. Her mother has been in and out of substance abuse treatment since Vanessa was twelve. Vanessa’s mother is also a survivor of domestic violence, perpetrated by Vanessa’s father. Vanessa’s mother left Vanessa’s father as a result of the violence and became the sole caretaker of Vanessa and her siblings when Vanessa was about five years old. Vanessa’s mother had numerous partners, one of whom molested Vanessa when she was 11 years old. Vanessa never told her mother about this and began cutting herself shortly after the sexual abuse began.

Two years ago, when Vanessa was seventeen, she became involved in an intimate relationship with Adam. Two months before her high school graduation she dropped out of school to move in with Adam. Right after she moved in, she found out that Adam was using cocaine. Soon after she moved in, Adam also started hitting her and the beatings began to occur at least once a week. Adam hit her in the face and head leaving visible injuries. He would ask her not to go out when the injuries showed. Adam made other demands that were impossible for Vanessa to meet and then “punished” her for her “failures.” She says, “I was like a prisoner or something. He was always telling me, ‘Do this; do that.’” Sometimes Vanessa could avoid an attack by promising him over and over that she wouldn’t leave him. Frequently, the attacks occurred when Adam had trouble finding the money to get drugs, yet Adam would almost always find a way to get high after an attack on Vanessa. Adam never hit Vanessa when he was on drugs. Vanessa says, “I know it sounds bad; I know it’s wrong, but I liked it when he was wired. I wanted him to use drugs because then I knew he would leave me alone.”

Adam was incarcerated for two months beginning in November. He began attending Narcotics Anonymous meetings while he was in jail. Adam had been sober and violence-free from November until the last incident. He lives in a residential treatment program during the week and has been seeing Vanessa on the weekends. Adam and Vanessa were both hoping to find housing through the public housing system when he finishes his program. Before the latest incident of violence Vanessa had been looking for a job and wanted to go to college. Vanessa had been hopeful that the violence was in the past. “It was a long time ago,” she said. Vanessa said Adam had been talking to her about things now and things didn’t always have to be his way so much.

Last month Adam hit Vanessa again. Adam says he doesn’t remember hitting Vanessa. He told Vanessa he does not want to talk about it. Vanessa was not the first of Adam’s girlfriends that he hit. Adam’s parents abused him when he was a child. Vanessa and Adam have an 18-month-old daughter. Vanessa has left and returned to Adam a number of times. Most recently she left him, going to stay at the local domestic violence shelter for 30 days. Following her shelter stay, Vanessa was able to access transitional housing; however, she has not been open with staff about her partner’s drug use or hers. Vanessa occasionally visits her mother’s house where her mother continues to use drugs. Now she is in
transitional housing and struggling to maintain her goals. She is not eating or sleeping and seems hostile and nervous when she is not crying. She has been cutting herself again and is avoiding staff and laying low.

Questions:

1. What concerns do you have? What info do you need?
   a. Describe potential safety risks and health care risks.
   b. How and where will you address the topic of substance abuse, mental health issues (like cutting and depression), and domestic violence/sexual assault in a trauma-informed manner?
   c. How do you provide a trauma-informed response to establish trust, triage competing concerns, and accommodate Vanessa’s needs?

2. Discuss steps you can take to provide a trauma-informed response to accommodate Vanessa’s needs and support safety, autonomy, and accountability within a voluntary services framework:
   a. For Vanessa
   b. For the 18-month old child
   c. For you and your agency

3. What are your local community resources and who are your community partners? How can they provide support for:
   a. Vanessa?
   b. Her partner?
   c. The child?
   d. You and your agency?

4. What plan can you put in place to ensure the best outcome?

5. You remind yourself it is not your job to cure these problems, but you find yourself angry because these people won’t do you think is best.
   a. What steps can you take to foster safety, sobriety, and wellness in a non-judgmental and empowering way?
   b. What steps can you take to ensure self-care and avoid burnout?

*Case Study adapted from Laura Subin, VT; Questions by Patti Bland, NCDVTMH 2014*
Sheila’s Story: A Struggle with Violence and Addiction

Sheila was born in Canada in 1983. She had problems learning to read and dropped out of school at 16. By the time she was 19, she had severed ties with her family and was looking to escape from an abusive boyfriend. She decided to flee with a friend who was heading to Dakota, believing she could build a new life there. Her friend said people she knew would put them up and that there were lots of ways to find work in the city, even without documentation. When they arrived, though, things were not as Sheila imagined they would be. Her friend found a place to stay, but there was not room for Sheila and quickly the friend did not come to meet her and refused to speak to her on the phone. Sheila found herself homeless, terrified and completely alone.

After a couple of weeks of living on the street, Sheila met Don, the man who would become her husband and the father of her children. Don was willing to help Sheila even though he was also homeless. He knew where to find soup kitchens and outreach centers. He helped her to survive. He also kept her company and made her feel as though somebody cared about her. He showed her the ropes and they passed the time together sneaking into movies, playing cards, or walking around town. She began to rely on Don’s companionship, his kind words and his support. She fell in love with him.

She soon realized, though, that life with Don was not going to be easy. He started free-basing in front of her and it seemed as if, more and more, drugs controlled his moods. He would be nice to her as he got high, then angry as he came down and even more angry if he wanted more drugs and had no money to buy them.

Don wanted Sheila to “party” with him. At first when she refused, he seemed only disappointed and Sheila felt guilty for letting him down. Sheila was terrified of losing Don and was afraid that he would abandon her if she weren’t fun to be around so she decided to try it. And at times it was fun. The high felt good, made Sheila feel close to Don and allowed her to forget the struggles of street life. But those times never lasted very long and coping with daily needs became harder each time she came down.

Don and Sheila were homeless together for over a year, living in and around the town. During that time, Sheila became increasingly dependent on drugs and on Don – in spite of the ways he often treated her. She also became increasingly jumpy, had difficulty sleeping, and frequently had dreams that terrified her. When Sheila could sleep she often woke up screaming because her nightmares were so bad. More and more, Don demanded to control Sheila’s life. He insisted on knowing where she was at all times. He became irrationally jealous of other men, accusing her of being a “fat slut.” He became violent. He slapped her whenever they argued and sometimes punched her with a closed fist.

In spite of his jealousy, Don decided it was Sheila’s responsibility to earn money for them and that the only way she could do that was from trading sex for money. When Sheila refused, Don hit her. She began to comply. Don told Sheila when she had to go to work. He told her where to stand and walked the street scanning for customers for her. When he saw someone he thought was looking, he forced her to approach whomever he had chosen. He then followed Sheila and her customer to a hotel and waited while they were inside. Don timed how long Sheila was in the hotel and was irate if he felt it was too long. He also got angry if he thought too much time passed between sexual encounters, generally allowing
Sheila less than an hour of respite between encounters. Immediately after Sheila came out from being with a customer, Don forced her to turn the money she had received over to him. After forcing her to engage in commercial sex work, Don often raped Sheila. Before attacking her, he would force her to describe her tricks in graphic detail. If she refused to tell him or refused to have sex, he beat her. Generally when this happened, Sheila coped by zoning out and feeling separate from her body.

In 2009, Sheila became pregnant. She wanted Don to sponsor her for citizenship so that she could get a legitimate job, but he refused. He continued to force her into commercial sex, insisting that it was the only way they could buy things for the baby or the apartment. When Sheila got paid, though, Don took the money and spent most of it on drugs.

She begged to be allowed to stop the commercial sex but Don would not listen. On one occasion as they were arguing because Sheila wouldn’t work the streets, Don pushed her down a flight of cement steps. Don did not take Sheila to the hospital in time and she lost the baby. She decided it was time for a break from Don after nearly bleeding to death. She was not really sure what she wanted, but after being released from the hospital she called a domestic violence/sexual assault shelter and was astonished when she was accepted into the program. After a 60-day stay Sheila was accepted into a transitional housing program. Sheila has not discussed the commercial sex nor using drugs to any of the advocates she has met so far.

Although she is glad to have a place to stay, Sheila has nightmares whenever she tries to rest. She is very jumpy and easily startled. She is convinced Don will find her and make her suffer. Even though Sheila is afraid of Don, she is more afraid of the advocates and other professionals. She is having a hard time getting her work visa and has been discouraged. She fears she will be kicked out if the staff find out about her ongoing drug use and the commercial sex. She is spending a lot of time faking a positive attitude, but is resentful and doesn’t know whether to ask for help or run. She can’t seem to follow all the rules and feels overwhelmed. Why bother trying? She questions whether life is worth living.

Questions:

1. What concerns do you have? What info do you need?
   a. Describe potential safety and health risks.
   b. How and where will you address her experiences of domestic violence and substance abuse in a trauma-informed way?
   c. How do you provide a trauma-informed response to establish trust, triage competing concerns, and accommodate Sheila’s needs?

2. Discuss steps you can take to accommodate Sheila and address all of the struggles she is experiencing:
   a. Domestic violence/sexual assault
   b. Trauma
   c. Substance Use
   d. Suicide Ideation
   e. Additional struggles

3. What are your local community resources and who are your community partners? How can they provide support for:
a. Sheila?
b. You and your agency?

4. What service plan can you put in place to ensure the best outcome?
5. You remind yourself that it is not your job to cure these problems, but you find yourself angry because Sheila won’t do what you think is best.
   a. Given that you work in a voluntary services model program, what steps can you take to foster safety, sobriety, and wellness in a non-judgmental, trauma-informed, empowering way?
   b. What steps can you take to ensure self-care and avoid burnout?

*Case Study adapted from Laura Subin, VT; Questions by Patti Bland, NCDVTMH 2014*
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Substance Use/Abuse in the Context of Domestic Violence, Sexual Assault, and Trauma

By Patricia J. Bland, M.A., CDP

Safety and Empowerment:
Advocates benefit from on-going training about substance use in the context of domestic violence/sexual assault, trauma and mental health because the issue of substance use and substance abuse coercion can affect a survivor’s safety, empowerment, and capacity to benefit from services. Accommodations are necessary to reduce risk from an abuser using substances as a tool to gain or maintain power and control as well as to support survivors at risk for harm from substance use or the experience of a substance use disorder. It is crucial for trauma-informed advocates and allies to understand how substance use affects safety as well as how to accommodate survivors in an empowering and non-judgmental manner. ALL program participants should be offered safety strategies and options to reduce risks associated with substance use, substance abuse, and the experience of a substance use disorder. (*Note: The term substance use disorder is often used interchangeably with terms such as chemical dependency or addiction, however substance use disorder is currently considered the proper term.)

Our Mission is one of Inclusion and Anti-Oppression:
Women who misuse substances frequently experience bias and stigma and are routinely denied access to DV/SA services and affordable treatment due to factors beyond their control. Advocates benefit from training designed to help them become self-aware of their feelings about substance use, misuse, and addiction as well as how those feelings affect both them and the people they serve. Advocates also benefit from a clear understanding of program policy and knowledge of local substance abuse resources. Most critically, advocates must have training to know what to say and how to respond when substance use is an issue.

Disability Rights:
Recovery status is a disability rights issue. It is crucial to train advocates on Americans with Disabilities Act and Fair Housing rules and regulations to ensure a survivor’s right to accommodation under the law. Such training should explore not just the limits of the law but what stops us from doing more to support the people we serve.

Collaboration:
Ongoing local, community-based training works best when advocates establish relationships with collaborative partners in the substance abuse field who are knowledgeable about DV/SA and willing to provide information about substance use from a feminist perspective. Such partnerships can provide invaluable guidance and support for both advocates and survivors.

Education:
Substance use effects thinking, behavior, memory, and emotions. It impacts humans across all aspects of their being. Substance abuse issues are complex and should be addressed as a base-line training issue offered to staff and volunteers. Encourage
advocates to consider taking a basic community college level survey course on addiction issues as well as coursework explaining the physical, emotional, cognitive, behavioral, social, sexual, economic, and spiritual impact of substance use, abuse, and addiction. Advocates can benefit from follow-up workshops, books and on-line resources. The National Center on Domestic Violence, Trauma, and Mental Health can provide web based resources at our website: http://www.nationalcenterdvtraumamh.org/. Other web-based, telephonic, and in-person training and technical assistance are also available for advocates and their community partners.
Skit: Mary Has All Kinds of Troubles

Advocate: Why is this woman wearing sunglasses?

Substance Abuse Counselor: Why is she wearing long sleeves in the middle of summer?

All Helping Professionals (in unison): Hmmmmmmmmmm.

Advocate: Maybe she has a black eye ... and bruises on her arms. I wonder if she’s being abused.

Substance Abuse Counselor: Maybe she’s wearing sunglasses to hide her pupils. And long sleeves to hide needle tracks on her arms. I’ll bet she’s an IV drug user.

Social Worker: Maybe she’s wearing everything she owns so she doesn’t have to carry it around with her. She could be experiencing homelessness.

Mental Health Professional: She could be trying to attract attention to herself by dressing in an unusual manner. Attention seeking behavior is a classic symptom of borderline personality disorder.

Mary: To tell you the truth, I’m not really sure why I’m here.

All Helping Professionals (in unison): Hmmmmmmmmmm.

Substance Abuse Counselor: Sounds like denial to me. Drug addicts are chock full of denial, you know.

Advocate: Sounds like she lacks awareness of abuse issues. I think she needs some domestic violence education.

Social Worker: Sounds like she lacks awareness of the community resources that are available to her. We need to talk with her about housing options.

Mental Health Professional: She sounds defensive. You know how touchy borderlines can be.

Mary: [Scratches herself.]

All Helping Professionals (in unison): Hmmmmmmmmmm.

Substance Abuse Counselor: I think she’s got coke bugs. She’s in withdrawal.

Advocate: Oh no! I hope it’s not head lice or scabies again. We had that at the shelter last week.
Social Worker: She could just need to take a shower and wash her hair. A person without housing might not have access to facilities where she can do this.

Mental Health Professional: She’s going to be asking for some kind of medication. These borderlines are in our office every five minutes wanting something.

Mary: I’m afraid to go anywhere. I know I’m being watched. I’ve been seeing the same car everywhere.

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: Could be drug-induced paranoia. She must owe money to her dealer. Or maybe she has a warrant out for her arrest.

Social Worker: Maybe she’s afraid of getting arrested for vagrancy.

Advocate: I think she’s being stalked. We need to help her get an order of protection.

Mental Health Professional: But you know, borderlines love a good crisis. It helps them feel more alive.

Mary: My partner won’t let me go to group sessions.

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: She’s co-dependent, for sure.

Advocate: This is classic batterer behavior. We mustn’t blame the victim.

Mental Health Professional: Borderlines always have to be in a relationship, even if it’s abusive.

Social Worker: She might not like filling out the forms. They always ask for an address.

Mary: Okay, I know I need some kind of help. My life is one crisis after another.

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: You have a substance use disorder. You need treatment, and some 12 Step meetings.

Advocate: You are the victim of a crime. You need justice. And some education about the dynamics of abuse.

Social Worker: You lack adequate housing. You need some referrals.

Mental Health Professional: You have a mental illness known as borderline personality disorder. You need therapy. And perhaps some medication.
Mary: Since I seem to have all these problems, where on earth do I start?

All Helping Professionals (in unison): Hmmmmmmmmm. Substance abuse counselor: Your priority must be sobriety. Advocate: Our priority is your safety. Substance abuse counselor: You must accept your powerlessness.

Advocate: You need to be empowered.

Substance abuse counselor: You need to look for your part in your problems.

Advocate: You are not responsible for what happened. The perpetrator must be held accountable.

Substance abuse counselor: You need to change yourself.

Advocate: We need to change society.

Mary: You people are driving me crazy. I’m out of here!

All Helping Professionals (in unison): Hmmmmmmmmm.

Substance Abuse Counselor: She hasn’t hit bottom yet. Relapse is part of the recovery process for people with substance use disorders.

Advocate: It takes a survivor an average of seven tries before getting out of an abusive relationship.

Social Worker: She’ll be back when the weather starts getting cold.

Mental Health Professional: She’ll be back when she has another crisis. Got a stop watch?

Substance Abuse Counselor: She’ll be back.

Advocate: Yes, she’ll be back.

Social Worker: Uh huh. She’ll be back.

All Helping Professionals (in unison): She’ll be ba-a-a-ck ...
DISCUSSION QUESTIONS

When the skit is finished, here are some questions to consider:

Can anyone relate to what you just saw?
What stood out for you the most?
What other labels might someone be burdened with?
What feelings did this bring up?
How can providers make sure that people are not re-victimized when they seek help?
What does respectful advocacy or treatment look like?
How should Mary have been treated?
What steps can be taken to ensure that people’s needs are met?

Skit adapted from model developed by King County Coalition Against Domestic Violence Interdisciplinary Training Planning Committee, 2000.

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Adapted from Real Tools: Responding to Multi-Abuse Trauma, ANDVSA, 2011
Instructions for Skit:
Mary Has All Kinds of Troubles

This skit can be used in a variety of settings: to cross-train advocates and other providers; to generate discussion in a support group meeting; or to educate the public about the fragmented social services system often encountered by people who seek help for both trauma and co-occurring issues.

**Note:** You will need to do some advance planning for this group. For each role, you may want to use a yellow highlighting marker to highlight that actor’s part in their copy of the script to make it easier to follow. (For example, you will highlight the “substance abuse counselor's” part in the copy of the script that you give to the person playing the role of the “substance abuse counselor,” the social worker's part in the copy of the script you give to the “social worker,” etc.)

**CAST:** Mary (an individual seeking help from the social service system), 4 Helping Professionals (Advocate, Substance Abuse Counselor, Social Worker and Mental Health Professional) and 1-4 Volunteers to tape labels on the Mary as they are mentioned by the Helping Professionals. The facilitator or a group member can moderate a discussion following the skit.

**PROPS:** 4 chairs up front for Helping Professionals. Sunglasses for Mary to wear. Masking tape and labels for Volunteer to tape to Mary. Make labels on 8x10 sheets of paper. Laminate them if you want to re-use them.

**LABELS NEEDED:** Battering Victim, IV Drug User, Homeless, Borderline, Denial, Needs DV Education, Needs Housing, Defensive, In Withdrawal, Head Lice and Scabies, Not Clean-Needs Shower, Wants Meds, Paranoid, Owes Money, Has Warrants, Stalking Victim, Crisis Junky, Co-dependent, Victim, Relationship Addict, Chemically Dependent, Crime Victim, Mentally Ill, Chronically Homeless, Powerless, Must Hold Batterer Accountable, To Blame for Her Part, Needs to Change, Hasn’t Hit Bottom Yet, Get Sober, Get Safe, Get Well, You’ll Never Change, You’ll Be Back.

**AUDIOVISUAL NEEDS:** If the group is large or group participants’ voices are soft, you may want to use a cordless or hand held microphone for Mary and also for the Helping Professionals.

**SCENE:** “Mary” puts on a pair of sunglasses and a large, long-sleeved shirt and stands in front of a row of 4 “Helping Professionals,” seated in chairs. While the “Helping Professionals” are speaking, “Volunteer” tapes labels on the Mary to match the labeling language. Advise the Volunteer not to worry if labels get out of sequence.

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Adapted from *Real Tools: Responding to Multi-Abuse Trauma*, ANDVSA, 2011
Trust Isn’t Always Easy

People who have been traumatized 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.** People with multiple issues may have been passed from one agency to another for years without getting their needs met. Or they may have encountered providers who treated them in ways that felt confusing or disrespectful.

- **Fear of authority figures.** People with a history of trauma have often encountered authority figures who abused power, discounted them, or blamed them for their problems instead of helping them.

- **Fear of legal sanctions.** Survivors may fear prosecution if they disclose illegal behavior such as drug use, theft, or sex work. Someone who has been incarcerated may fear going back to jail or prison. Someone with immigrant status may fear being deported.

- **Fear of being judged.** People with multiple issues may have heard repeatedly that their problems are caused by their own behavior, lack of personal responsibility, inappropriate decisions, or bad character traits.

- **Fear of being discounted.** People who have been victimized by interpersonal violence often have a history of not being believed when they are telling the truth, especially if they are navigating other 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, disability, socioeconomic background, substance use history, or mental health status.

- **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 physical or developmental disabilities, may fear being judged incompetent to provide adequate parenting.

- **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 sex work, or past incarceration. People who receive public assistance or live in subsidized housing may fear losing benefits or being evicted 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 they do may try to impose their own solutions and values.
• *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.
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. 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 person who has been abused or sexually assaulted is angry or doesn’t trust you right away. Allow people you serve to take as much time as they need to begin to trust you. Understand that this lack of trust has more to do with their life experience and your role than it does about you personally.

- Recognize all people need to earn trust and advocates, counselors, and authority figures are no exception. Trust isn’t automatic just because someone wants to help or is in a position of authority.

- Encourage individuals to participate in developing safety, service, and/or treatment plans. This can help give them a sense of control.

- Explain what you are doing, and why, up front. No surprises. If people we serve suspect that information is being withheld from them or that they are being manipulated in any way, trust often evaporates.

- Understand that confidentiality is paramount in gaining trust, as well as an ethical imperative.

- Explain the limits of your confidentiality at the beginning of the intake process, before anyone begins talking. This may impact which issues an individual feels safe sharing with you.

- Live the expectations you have of others. If we have a different set of standards for ourselves than we have for the people we serve, we convey the message that 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.
Trauma Informed Services: It Takes Time and Effort to Build Trust
By Patricia J. Bland, M.A, CDP

- People who experience multiple barriers have often been traumatized.

- Traumatized people 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.

- Many people we serve have been harmed or betrayed by the people closest to them. Those who have developed a substance use disorder have been betrayed by their own bodies. Given this reality, trauma-informed service provision is critical.

- Women are under-represented in alcohol and other drug treatment settings, less likely to have access to affordable treatment, and frequently lack insurance. Women are often responsible for child-care, but the majority of treatment programs do not provide this service during treatment.

- Additionally, women are often coerced into using substances by abusers who prevent them from seeking treatment and sabotage their recovery. They are often shamed, blamed, threatened, and terrorized by abusive partners who find it easier to control them when they are under the influence.

- Batterers, offenders and people who routinely hurt others are well aware many domestic violence/sexual assault programs may deny or limit services for survivors when alcohol or other drug use is perceived as a problem by staff.

- Batterers are also aware survivors who experience a substance use disorder face bias and discrimination in court and in other arenas. This bias is compounded when the person experiencing a substance use disorder is a mother.

- To paraphrase Carole Warshaw, MD, “The harm survivors experience takes place in the context of an abusive relationship; the support we offer also takes place in the context of relationship.”

- Trauma-informed service provision, like advocacy based counseling, recognizes it takes time and effort to develop trust. We can provide trauma-informed counseling and empowering advocacy-based counseling more readily if we can remove barriers to trust and develop supportive relationships with the people we serve. To accomplish this goal, we ourselves must be trustworthy and nonjudgmental.

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Adapted from Real Tools: Responding to Multi-Abuse Trauma, ANDVSA, 2011
Service Barriers
By Patricia J. Bland, M.A. CDP

Take a few moments to read the questions below. Discuss your reaction. Advocates are often concerned that a lack of knowledge about substance use can pose problems for survivors and themselves. They often ask questions such as:

Q. “I have had no training on substance abuse – how does that affect survivors?”

The experience of either substance use coercion or a substance use disorder makes safety planning and advocacy in the context of both domestic violence/sexual assault and substance use critical. When advocates lack knowledge of how substance use affects safety planning and advocacy, it limits their effectiveness and does little to reduce survivor risk or increase options.

Additionally, failing to understand substance use in the context of domestic violence/sexual assault may limit survivors’ ability to feel welcome if they are hiding substance use, are ashamed of their experience of substance use coercion, or feel their service needs cannot be adequately met. Survivors may believe they cannot safely disclose their situation. There is much less “disruption” when programs are “prepared for arrival” and advocates have received training to respond openly to identified needs that are often unstated if survivors are afraid, embarrassed, ashamed, or concerned about being judged or denied services.

Survivors who are “covering up” may have difficulty trusting staff and may be reminded of their abusive relationship. This in turn can elicit traumatic memories or lead to conflict. It also has the potential to increase stress making it more likely a survivor will exit the program. Additionally, the stress of seeking help while “covering up” may escalate substance use or psychiatric symptoms for some of the survivors we serve.

Q. “I don’t have adequate training to handle persons with substance abuse problems – how does that affect me as an advocate?”

Advocates without substance use training in the context of domestic violence/sexual assault often tell me they experience a lack of confidence in their ability to respond to survivors who are using substances. They also express fears that something very bad will happen and also worry about the safety of the house, as well as their own safety. Advocates may be especially worried they will not be able to keep children safe. Many state, “I did not sign on to be a substance abuse counselor. This is too much for me.” Lack of knowledge about their role contributes to stress.

This lack of knowledge can also lead to bias, anger, and burnout. When advocates are ill informed and feel stressed, services are generally NOT trauma-informed. Advocates may feel threatened or under siege. Those in recovery may find it hard to work with people
actively using. Others may find uncomfortable memories of past or current relationships linked to substance abuse and interpersonal violence may be elicited. Advocates without adequate training and support may also feel very overwhelmed.

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Adapted from Real Tools: Responding to Multi-Abuse Trauma, ANDVSA, 2011
Capsule Comments: Alcohol and Pills – A Feminist Issue
By Patricia J. Bland, M.A., CDP

Women need significantly less alcohol or other drugs to be more intoxicated or impaired than men. It takes considerably less time for women to move from an early to late stage Substance Use Disorder. This means less substance use over less time leads to more significant damage and greater lethality rates at an earlier age (Coughlin, 2000).

Psychotropic medication is over-prescribed for women survivors of domestic violence (Minnesota Coalition for Battered Women, 1992). 70% of prescriptions for tranquilizers, sedatives, and stimulants are written for women (Roth, 1991).

Anxiolytics (benzodiazepines such as Valium, Librium, Xanax, Klonopin, Ativan, and Restoril) have high potential for misuse. The potential for abuse and dependence on sedative hypnotic drugs such as benzodiazepines is especially high for people with a history of substance abuse.

Substance dependence can develop in as little as two weeks. Withdrawal symptoms can be life threatening if medication is stopped abruptly following chronic use.

Benzodiazepines and other sedative hypnotic drugs (e.g. barbiturates) produce central nervous system (CNS) depression and are commonly used to treat insomnia and anxiety. Use of these substances can affect thinking, judgment, and emotional responses.

Alcohol is also an anxiolytic. Withdrawal from alcohol and/or these meds can lead to life threatening symptoms that pose considerably higher risk for harm than withdrawal from opiates and other types of drugs. Overdose potential is especially high if these drugs are mixed with alcohol and can be lethal as well. Cessation of drinking and other anxiolytics can lead to sleep disruption for up to two years.

Many survivors tell advocates these drugs make it possible for them to stay in an abusive relationship longer, take the edge off, and make the abuse bearable. They also describe numbing out and not caring. “The drug didn’t hurt as much as reality hurt” (Bland & Edmund, 2008).

Survivors tell advocates using alcohol and other anxiolytics make “the safety plan fly out the window” (Edmund & Bland, 2011). Women also reveal, when it is safe to do so, that their partners use coercive control, label them as crazy or addicted, withhold their medications, or force them to misuse pills or alcohol to be “better in bed.”

A federal longitudinal study found two-thirds of women in treatment experienced interpersonal trauma before any significant use of substances occurred; one-third of women experienced initial interpersonal trauma while under the influence. Each person’s story is unique and needs to be heard and believed. Both groups blame themselves and benefit from being told, “This is not your fault. No one has the right to hurt you whether you are drinking or not.”
References


See also:
SAFETY ISSUES AND MULTI-ABUSE TRAUMA

People experiencing simultaneous struggles such as a substance use disorder, mental health concerns, disability, societal oppression, or poverty may find 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.

Experiencing simultaneous issues make it harder for survivors of interpersonal violence to get safe in a variety of ways:

• The existence of domestic violence and substance use (or misuse) together 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 survivor receiving methadone on a daily basis could easily be stalked due to the regularity of receiving medication.

• 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. The fear of having children removed is also a significant, and realistic, fear for folks experiencing psychiatric symptoms.

• 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).

• Members of an oppressed group may face additional 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 transgender identified 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 undocumented 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 places outside of the U.S., which may leave them in fear of deportation (Song & Thompson, 2005).

Inability to get safe or heal from interpersonal violence 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).
References


Safety Concerns: Memory Deficits and Physical Harm
By Patricia J. Bland, M.A. CDP

• Substance abuse coercion: Abusers may coerce or force partners into using alcohol or other drugs. In addition, survivors of abuse may use or abuse alcohol or other drugs to help them survive and cope with the abuse and its traumatic effects. Abusers rely on stigma associated with substance abuse to undermine and control partners. They also actively undermine partners’ efforts to get sober and use substance use as a threat to prevent partners from seeking help. Memory deficits and significant physical harm can occur that make it difficult to stay safe.

• Memory deficits: A blackout is a period of amnesia during which one is actively engaged in behaviors (walking/talking) but the brain is unable to store long-term memories of the events, leaving one unable to recall the events once one is no longer intoxicated. It is possible for one to experience blackouts while appearing only moderately intoxicated. Blackouts usually happen in a drinking setting during which time one may not appear to be intoxicated (Johnson, 1980). A person may also drive or carry on a conversation in a nearly “normal fashion.”

• It is important to understand ‘blackout’ and ‘passed out’ are two different states. People in a blackout are awake and may be walking and talking but substances affect their memory. Neither hypnosis nor ‘truth serum’ will restore their memories. Unlike people who experience dissociation, people experiencing a blackout or whose memories are otherwise affected by substance use can never retrieve those memories (amnesia due to blackout) or experience fully accurate recollection due to distortion in thinking. This distortion in thinking is associated with inaccurate memory formation as opposed to memory storage. It is often described as ‘euphoric recall’ (Johnson, 1980) or more commonly referred to as ‘stinking thinking’ in AA or NA circles.

• Physical harm: The term ‘passed out’ is less clearly defined, but generally is used to mean either falling asleep from excessive drinking or other drug use – in other words, literally drinking or drugging oneself into an unconscious state. People who are passed out are generally unresponsive and unconscious. They may be at high risk for death from overdose either through breathing cessation or aspiration (inhaling vomit). If you are concerned because someone under the influence is passed out, non-responsive, breathing shallowly, struggling to breathe or not breathing, call 911 and seek medical assistance immediately.

References


(Note: Jean Kinney has updated this book in 2011 and again in 2014.)
MENTAL HEALTH AND SUBSTANCE ABUSE COERCION
Safety and Well-Being Tipsheet Series

Intimate partner violence is a pattern of coercive behaviors designed to dominate and control a partner through fear and intimidation. Tactics may include...

- Physical abuse
- Sexual abuse
- Psychological and emotional abuse
- Economic abuse
- Isolation
- Threats related to children (e.g., to take custody)

Part of the reason why these tactics work is that they rely on discrimination and stigma, such as...

- Racism
- Sexism
- Heterosexism, homophobia, biphobia, transphobia
- Discrimination based on physical or psychiatric disability
- Stigma related to HIV status
- Stigma related to mental health
- Stigma related to substance abuse

Understanding how abusive tactics work and how they can affect us can help us to access safety, heal from the traumatic effects of abuse, and support others to do the same.

**Mental health coercion:** Survivors may experience mental health effects of abuse. In addition, individuals who have a psychiatric disability are at a greater risk of being abused, and the abuse may cause mental health symptoms to get worse. Abusers rely on stigma related to mental health to undermine and control their partners. If you answer yes to any of these questions, you might be experiencing mental health coercion:

- Has your partner ever done things that cause your mental health symptoms to get worse?
- Has your partner ever tried to prevent or discourage you from accessing mental health treatment or taking your prescription medication?
- Does your partner restrict or interfere with your ability to speak for yourself with doctors or mental health professionals?
- Has your partner ever tried to control your prescription medication (e.g., by forcing you to take an overdose, giving you too much or too little medication, or preventing you from taking it at all)?
- Has your partner ever threatened to have you committed to an inpatient psychiatric institution?
- Has your partner blamed you for the abuse by saying that you’re the one who is “crazy”?
- Does your partner tell you that you are lazy, stupid, “crazy,” or a bad parent because of your mental health condition?
- Has your partner ever used your mental health condition to undermine or humiliate you with other people?
- Does your partner tell you that no one will believe what you say because of your mental health condition?
• Has your partner ever threatened that you will lose custody of your children because of your mental health status?

Substance abuse coercion: Abusers may coerce or force their partners into using alcohol or other drugs. In addition, survivors of abuse may use or abuse alcohol or other drugs to help them survive and cope with the abuse and its traumatic effects. Abusers rely on stigma associated with substance abuse to undermine and control their partners. If you answer yes to any of these questions, you might be experiencing substance abuse coercion:

• Has your partner ever made you use alcohol or other drugs, made you use more than you wanted, or threatened to harm you if you didn’t?
• Do you ever use alcohol or other drugs to numb the effects of abuse?
• Does your partner control your access to alcohol or other drugs?
• Does your partner justify name-calling, criticizing, belittling, and undermining you based on your use of alcohol or other drugs?
• Has your partner told you that you are to blame for abuse or sexual assault because of your use of alcohol or other drugs?
• Has your partner ever forced or coerced you into engaging in illegal activities (e.g., dealing, stealing, trading sex for drugs) or other activities that you felt uncomfortable with in order to obtain alcohol or other drugs?
• Have you ever been afraid to call the police for help because your partner said you would be arrested for being high or your partner said you would lose custody of your children because of your alcohol or drug use?
• Has your partner ever tried to manipulate you by making you go into withdrawal?
• Has your partner ever stopped you from cutting down or quitting alcohol or other drugs when you wanted to?
• Has your partner ever prevented you from attending a recovery meeting, interfered with your substance abuse treatment, or sabotaged your recovery in other ways?

If you are being abused, call the National Domestic Violence Hotline at (800) 799-SAFE (7233) or (800) 787-3224 (TTY).

For more information on the intersection of domestic violence, trauma, mental health, and substance abuse, contact the National Center on Domestic Violence, Trauma & Mental Health at (312) 726-7020, 312-726-4110 (TTY), or info@nationalcenterdvtraumamh.org.
Substance Abuse: Building a Bridge to Safety for Survivors

By Patricia J. Bland, M.A., CDP and Erin Tinnon, MSW
Patricia J. Bland served as the Program Manager for the Seattle based Alcohol Drug Help Line Domestic Violence Outreach Project and as an advocate at New Beginnings for Battered Women and their Children for over ten years, and joined NCDVTMH in 2012 as the Director of Substance Abuse Training and Technical Assistance. The impact of her over 20 years of work at the intersection of substance abuse, sexual assault, and domestic violence changed our fields and will continue to ripple out in ways that move us all forward for many years to come.

Erin Tinnon has worked with survivors and folks navigating various levels of substance use for over twelve years, and is completely honored to have learned from, worked alongside, and been friends with Patti Bland. Contact Erin by email at etinnon@ncdvtmh.org

_The quotations accompanying this article come from “Women Talk about Substance Abuse and Violence” ten women interviewed by Debi Edmund and Patti Bland; Edited by Debi Edmund, June 2000._

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*A note about terminology: You will see terms like addiction, substance use/misuse/abuse, and substance use disorder used often in this article. While each person conceptualizes, talks about, and relates to their own experiences and understanding of substances in their lives differently, the term used by the American Psychological Association is currently “substance use disorder.” The authors of this article understand that many people don’t relate to or appreciate labeling themselves with a disorder. This combined with the fact that our language so often changes to describe human experiences, has lead us to do our best to vary the terminology throughout the article. It is always best to check with survivors and substance users about the terms they prefer for themselves.*
Introduction

Advocates for survivors of domestic violence and sexual assault often neglect to screen for substance use / abuse. Failure to ask key questions or recognize addiction cues may stem from: lack of time, a sense of helplessness to assess outside an area of expertise, fear of “opening up a can of worms”, concerns about angering or hurting a survivor’s feelings, lack of knowledge of community resources, or a lack of trust in other system providers. These barriers are compounded if they exist within a culture that routinely denies access to services for survivors with substance abuse or addiction issues.

Why Screen?

Domestic violence and substance use/abuse often occur in tandem although research consistently shows that neither causes the other. Individually, each can be chronic, progressive, and often lethal. Together, severity of injuries and lethality rates climb (Dutton, 1992). Survivor’s advocates have an ethical responsibility to routinely screen for substance abuse issues and offer services to survivors who may be at an increased risk for more lethal domestic violence due to their own, or their partner’s substance abuse. Advocates need to ask survivors about both their own substance use as well as their partner’s substance use. “Nearly 75% of all wives of alcoholics have been threatened, and 45% have been assaulted by their partners” (AMA, 1994). Substance use and violence occur in lesbian, gay, bisexual, and transgender (LGBT) relationships at the same or higher rates as heterosexual relationships, but LGBT people are faced with additional barriers and challenges to receiving services due to lack of familial support, increased stigma and harassment (Stevens, 2012), and discrimination on behalf of service providers. A study in Memphis, Tennessee found in 94% of domestic violence calls, the assailant had used alcohol alone or in combination with cocaine, marijuana, or other drugs within six hours of the assault (Brookoff, 1997). Brookoff et al also found that 92% of assailants and 42% of victims in the Memphis study used alcohol or other drugs on the day of the assault (1997).

Finding out whether substance use or abuse is impacting safety and providing effective advocacy requires more than checking off boxes or asking questions from a list. While research supports universal screening, the first requirement for respectful screening is an honest evaluation of one’s own attitudes and beliefs about substance abuse and addiction.
Survivors who are using or abusing substances have many reasons to be distrustful of advocates and service providers, largely because of the shame and stigma that survivors and substance abusers experience. On top of that, they have been failed by their partner and by their drug of choice. Respectful screening involves conveying the message that substance abuse and violence can happen to anyone. Advise survivors: “Anyone is vulnerable; you are not alone should these problems be facing you.” A successful intervention requires internally moving beyond the notion, “Why don’t they just quit?” or “Why don’t they just leave?” Questions such as these convey a lack of knowledge and a failure to understand the complexity of safely ending a relationship with either a substance or an abusive partner. Honestly discussing sobriety as a safety risk is extremely important. A survivor’s decision to keep using or decline treatment, advocacy, or shelter should not be viewed as a failure. Recovery is both an option and a process that can take time. Screening and referral can help build a bridge from substance abuse and violence to safety for survivors and their children. Survivors facing the dual stigma of both substance abuse and domestic violence may be reluctant to openly speak up. Generally speaking, survivors do not self-identify as either addicted or as survivors unless their safety is assured. Safety includes knowing you are not being labeled or judged. Survivors who have used or abused substances tell us they benefit most from advocates who “try to make you feel like you aren’t the only one. And that somebody else did make it. And someone else has made a life for themselves. They try to make you feel that you’re not worthless or useless.”

**Screening In...Not Out**

Survivors who use or abuse substances typically experience barriers to services and are often denied shelter, housing, employment, child custody, health insurance, and other services. Impacted by both domestic violence and substance abuse, survivors are attempting to make it work in a world that condemns them for both their substance abuse and their partner. Failure to provide safe services for survivors who are using or trying to get sober is a form of institutionalized oppression. Shelter policies that deny access to services for an entire group of people are both discriminatory and oppressive and cannot be tolerated. The reason survivors should be screened for substance abuse is not to deny access to services but to improve advocacy and safety planning. Model programs welcome women seeking safety and sobriety and are

"It (using) kept me isolated so I stayed at home in my room with the curtains drawn. On top of him keeping me isolated and not allowing me to go anywhere. I think the biggest thing it did was keep me from getting out and getting the help I needed."

"For me the substance abuse when I first started using was over abuse, was over a rape, and so that's how I learned to cope with any type of abuse was to get high, and it made everything okay."

"All I know is when I was being abused, all I wanted was more and more. The marijuana wasn't enough. Then I started getting into the crack. It was easier just to stay stoned and numb and not have to deal with it. The drugs were what made me forget about all the abuse and set aside the fear and terror I had from the abuse and that was my only escape. It was a way to get away from my husband and not feel trapped."
committed to reducing service barriers and ending isolation for survivors and their children navigating substance abuse struggles.

A commitment to serve people dealing with both domestic violence and substance abuse requires critical thinking about domestic violence and sexual assault program policies. Policies supporting a sober environment must be balanced with guidelines allowing survivors who are unable to refrain from use to safely tell us if they need help. We must keep in mind that the immediate risk from domestic violence may be more dangerous than the risk from chronic drug or alcohol abuse. Also, we must recognize that health risks from overdose or withdrawal can be as lethal as any abusive relationship.

Ideally, substance use and abuse should be discouraged as a safety issue for those living and working in our shelters and programs. If programs uphold policies that state that it is unsafe for residents to be using substances, then they should apply those same rules to themselves. Too often there is a double standard for substance use management imposed on residents that employees and advocates do not apply to their own lives. Guidelines supporting both abstinence and harm reduction are important. This can be challenging for both survivors and advocates who may or may not experience problems with alcohol or other drugs. No access to alcohol or other illicit drugs within shelter programs is a minor inconvenience if you are not struggling with alcohol or drug use or experiencing a Substance Use Disorder. However, this inconvenience becomes a major barrier to safe services for survivors who are abusing substances. Survivors navigating addiction have a right to us to support their sobriety. To do so is empowering. To do so makes it possible for them to get free from both an abusive partner and the substances that put them at risk. Survivors also have a right to use substances in a way that makes sense for them without being in jeopardy for losing their housing. Our policies should allow people to stay when they need help rather than push them out.

**Understanding Domestic Violence, Substance Abuse, and Addiction**

Understanding the impact of dual problems may very well enhance a survivor’s chances for achieving both safety and sobriety. A correlation between substance abuse and domestic violence occurs in 55-99% of reported domestic violence incidents depending on what research one chooses to cite.
(Mackey, 1992; Bennett & Bland, 2008). Even though most people are neither struggling with substance abuse nor experiencing abuse in their relationships, if survivors experience domestic violence and develop a substance use disorder (SUD), risks to their health and that of their children increase significantly. Substance abuse may occur as a coping method some survivors use as they attempt to survive the ongoing threat of violence directed at them by an intimate partner seeking to gain or maintain power and control (Bland, 2012).

Some survivors may consider using substances less emotionally and physically damaging than facing daily bouts of physical, emotional, and sexual abuse with little to blunt the pain.

Survivors in abusive relationships may also use alcohol or drugs for a variety of other reasons including: coercion by an abusive partner, addiction, cultural oppression, over-prescription of psychotropic medication, or, for people leaving an abusive relationship, a new sense of freedom (Bennett & Bland, 2008, Real Tools, 2011).

It is critical for advocates to recognize the different safety and advocacy needs for survivors who are experiencing a Substance Use Disorder (SUD) versus those who use or misuse substances. Alcohol and drugs affect the brain and body whether or not a person is experiencing a SUD. Substance abuse is a destructive pattern of drug use including alcohol, which leads to significant (social, occupational, medical) impairment or distress. Often the substance use continues in spite of significant life problems related to that use. The Diagnostic and Statistical Manual V no longer uses substance abuse or substance dependence and instead uses Substance Use Disorder to describe a cluster of behaviors and pharmacological criteria that are often used in a diagnostic context (SAMHSA, 2014).

Substance use and misuse are behaviors, not character defects. According to the American Society for Addiction Medicine (ASAM), a Substance Use Disorder is not a behavior – it is a disease. When a person begins to exhibit symptoms of tolerance (the need for significantly larger amounts of a substance to achieve intoxication) and withdrawal (adverse reactions after a reduction of a substance) it is likely that the person has progressed from abuse to dependence and addiction (Lee, 2013). “One day I didn’t want to drink and I had to. It was the scariest feeling.” A SUD, according to the medical model, is considered a primary chronic disease with genetic, psychosocial, and environmental factors influencing its development and
manifestations. The disease is often progressive and fatal. Addiction is characterized by continuous or periodic impaired control over drinking alcohol or using other drugs, preoccupation with drugs or alcohol, use of drugs or alcohol despite adverse consequences, and distortions in thinking, most notably denial. While the medical model is widespread and most often used in substance abuse treatment settings, there are many other models that can be used to understand substance abuse, such as the Bio-Psycho-Social Model and the Sociocultural Model.

Although a person may choose to use alcohol or drugs, they are unable to choose how their body will respond to alcohol or drugs. Alcoholics and addicts do not cause addiction and they do not like it either. No one wants to be addicted to or dependent on a substance or experience the consequences of that substance abuse. An element of this addiction, according to the medical model, is that a person is unable to recognize the problem and believes that they do not have a problem with alcohol or drugs. This belief, combined with social acceptance of drinking or taking medications to kill pain, make it hard for people navigating substance abuse to seek or get the help they need. Many times people don’t seek help because of how difficult it can be. As advocates, we must remember and remind people that help is available and that long-term recovery is possible.

Supporting Recovery: Effective Safety Planning

Survivors who are abusing substances may have a hard time recognizing options or gauging their safety. Some survivors may experience blackouts. Blackouts may mean the absence of memories for some events. Experiencing a blackout does not mean a person has passed out or lost consciousness. Nor does it mean psychological blocking out of events or repression. A blackout is an amnesia-like period often associated with heavy drinking. People in a blackout state may appear to be functioning normally but later have no memory of what occurred as alcohol-induced blackouts affect a person’s ability to form new memories during a period of blackout (Kinney and Leaton, 1991; White, 2004).

Barriers to safety planning can include being unable to recall a safety strategy, not knowing how an injury was sustained, forgetting a court date, or failing to remember making a police report. These things can result from over-use of substances but also as a result of trauma and dissociation.

“If you sober up a perpetrator and he doesn’t have treatment for his issues, then what do you have? You have a sober perpetrator. And now he’s more aware.”

“This man tried to strangle me. After that happened, then I relapsed. And I was in relapse mode off and on for a whole year after that.”

“Going to a meeting wouldn’t be anything he would tolerate because there would be other men there...his controlling made it real difficult for me to do what I needed to do for myself.”
The only memory substance users have of what happens during use is the one that is formed when they are under the influence of alcohol or in a drugged state. Thus, if a person under the influence inaccurately perceives themselves as safe or “able to handle it,” sobering up the next day may not correct their impaired memory. This distortion of perception is termed euphoric recall and theoretically has the potential to increase risk for survivors (Johnson, 1980; Gorski, 1996).

While blackouts impact memory, there is no evidence to support the contention that a blackout alters judgment or behavior at the time of its occurrence (Kinney and Lepton, 1991; White, 2004). Thus, abusers/ batterers/ people who harm others cannot be excused for their behavior when they are under the influence merely because they cannot remember it. Euphoric recall, like blackouts, may be misused by batterers to minimize, rationalize, or deny their abusive behavior. “He was more abusive when he was drinking and he was abusive when he was not drinking.” “The abuse escalated, especially when he was coming down from coke, or if he had a hangover from coke.”

Advocates must consistently give the message that using substances as an excuse for violence is not acceptable. Collusion with this erroneous belief helps a person who is abusing their partner to avoid accountability for abusive actions and mistakenly encourages a survivor to believe once the substance abuse ceases that the violence will finally stop.

Recovery for women, especially women who have survived domestic and sexual violence, is all about empowerment. Recovery is built on an individual woman’s experience, strength, and hope, as well as her belief that change can successfully occur for herself and her children. Women may not be able to choose how their bodies respond to substances, but they have power to take action. This power may be reflected in their decision to go to whatever lengths are necessary to survive for themselves and their children – when they are ready and when it is safe to do so. Recovery can be compromised when domestic violence occurs. Abusers want to exert power and will use any strategy or tactic to maintain control over their partner, including coercing them to use substances against their will. Substance use coercion is a common experience for survivors who are navigating substance abuse – where their abusive partner uses their substance abuse to undermine them in custody battles; discredit them with friends, family, child protective services, immigration authorities and courts; and generally compromise their ability to access services that might otherwise discriminate.

“[quote]I made it for 30 days. The minute I got out of a safe environment I was right back with the man and by midnight, using.”

“He was always saying the reason he would abuse me was because of my drug use, even though he had his drug use, or he would bring the drugs to me.”

Intravenous (I/V) drug users may be particularly vulnerable when targeted by batterers. Batterers can exploit illicit drug use as an opportunity to abuse their partner. Examples of abuse and substance use coercion through illicit drug use include: forcibly initiating or first enabling drug use in the context of a relationship, forcing a partner to trade sex for drugs, serving as the drug connection or determining the survivor’s drug supply, the abusive partner always shoots up for the survivor, and/or the batterer deliberately poses a risk for transmission of disease including hepatitis and HIV.

Both survivors and people who use/abuse substances are at risk for blaming themselves if they are unable to stay safe or sober. If the survivor is also struggling with substance abuse, the level of guilt and shame may be compounded.

**Talking to Survivors about Substance Use and Safety**

Many survivors find it easier to discuss their partner’s substance use before, or instead of, their own. This is particularly true of women in abusive relationships whose abusers drink or use drugs. A conversation about an abusive partner’s substance abuse gives one the opportunity to explore any history of substance, use, abuse, and possible experience of a substance use disorder.

If a survivor discloses that their partner abuses substances, an advocate might state: “Many survivors tell me their partners don’t want to drink or drug alone. How often have you found yourself stuck using when you didn’t want to?” This is a non-judgmental way to elicit information and provides an opportunity to explore drug related domestic violence and substance abuse coercion.

People experiencing domestic violence and a substance use disorder may believe that their safety will be assured if they just get sober. For a survivor who is experiencing a substance abuse problem or substance use disorder, getting sober can pose new risks. An abusive partner may increase violence as the recovering survivor becomes more self-reliant and “harder to control.” Before screening for substance abuse, affirm the person’s survival and praise them sincerely for finding their own way to cope. Appropriate advocacy includes validating a person’s survival strategies as well as identifying risks. This should lead to

“I could not recover from substance abuse if I was still being physically abused, mentally abused, because I would be right back to using. So they walk hand in hand. I would not recover from one unless I address the other, and vice versa.”

“The more you tell your story, the more you talk about what you did to get clean and sober, the stronger it makes you the more you hear it. And the longer we’re away from the abuser, and the more education we get, and the more we talk to other people about it, the stronger we become, and the more aware.”
a discussion where you can include the following: “You deserve credit for finding a way to cope. Tell me, what made you able to survive? Many survivors tell me when they experience pain that they find a way to deal with it. Some survivors tell me they begin compulsively cleaning, others get into shopping, eating or not eating, sleeping a lot, or working too much. Have you tried any of these ways of coping? A lot of survivors tell me the best way to cope is to numb out by drinking and/or drugging. How often has this worked for you? Can you think of any reasons why drinking or drugging could be unsafe for you in this moment? What kinds of luck have you had with other coping skills?”

The Intervention is in the Asking

It is not necessary for advocates to become drug and alcohol counselors, but it is important for them to ask about substance use. Countless intervention opportunities are missed when advocates are afraid to ask lest they offend or view intervention as futile. The intervention is in the asking. When survivors are respectfully asked about both their use and their safety, they hear, even if they are not yet ready to listen or enact change immediately. Often survivors will later share comments such as, “You know, when you said...it really made sense to me.” Supporting survivors through their process of change requires an understanding that motivation comes from within. It also takes knowledge of local resources. Safety, reduction of harmful substance use, and sobriety are indeed possible. Acknowledging the person before you has managed to survive, sincerely appreciating their individual strengths, and recognizing their innate dignity can support their own process and help build a healthy and powerful alliance that benefits both survivors and their children.

Safety, reduction in harmful use, and sobriety can be addressed respectfully if we acknowledge both substance use (e.g., a class of wine with dinner), and being in an intimate relationship (e.g., dating or having a partner) is a common experience both for the survivors we serve and for us as advocates. This means misuse of substances or abuse within an intimate relationship could happen to anyone. This being the case, anyone could find themselves having a problem with substances or a partner through no fault of their own.

People who struggle with substance abuse don’t know when they have the first drink or take the first drug what the future will hold. They expect to “feel better” or “kill pain” and find themselves believing they can “control” it. Unfortunately, “I got clean and sober and started working, and putting money away to get out of the relationship. And I think he saw that. He became more demanding. Attempts to be controlling escalated. His abuse of the kids escalated, as I was sober. His attempts seemed more desperate.”

“Once I walked away from that abuse (domestic violence), I knew that the next thing I had to do was something about the substance abuse. And then when I made up my mind that I wanted to quit drugs also, the advocates at the shelter were right there for me, and got me into a treatment program.”
addiction is about loss of control and powerlessness. This loss of control and powerlessness does not mean that one is weak or helpless. Instead, those who experience addiction cannot reasonable predict what will happen when they use. One is powerless only in terms of how one’s liver, one’s body, and one’s brain respond once alcohol or other drugs are introduced inside it. Many survivors navigating substance abuse don’t want to stop using alcohol or drugs. They want the craving, the problems, and the pain of withdrawal to stop. They want to be like other people who can have a social drink or take medication without serious physical ramifications. Unfortunately, like someone discovering an allergy (e.g., an allergy to bee stings), a person discovering their addiction, once “stung,” must forever make accommodations or be aware of the potential consequences of life-threatening challenges with exposure to substances. Fortunately, we can support survivors’ empowerment through our knowledge of options and available resources. The National Center on Domestic Violence, Trauma, and Mental Health, SAMHSA (spell out), (*pull more places from the resource list) can all provide information about programs and options for addressing both domestic violence and substance abuse. Many resources are now accessible online.

**Support Groups and Treatment: Making Referrals**

When possible, encourage survivors struggling with substance abuse to consider attending a support group addressing issues pertaining to both domestic violence and substance abuse. Integrated support groups offer survivors a format to heal individually and collectively utilizing techniques that are applicable for the goals of safety, reduction in harmful substance use, and sobriety. The primary goal of successful groups addressing these issues is to be a safe place where survivors can tell their story, speak their truth, be believed, and begin the healing and connection process.

While substance abuse is often considered the “family disease,” looking for a “family cure” when domestic violence is present can be extremely dangerous. Survivors managing substance abuse should not be required to participate in family counseling or any counseling that includes their abuser. While a survivor managing the effects of substance abuse may choose to participate in counseling that includes their abusive partner, advocates should advise survivors of both the risks and limitations of such a plan. When referring people to substance abuse treatment programs, ask if their family counseling includes safety planning for children. In order to hold treatment programs accountable for

“**And it feels in the beginning like it is the end of the world, but it is actually the beginning of a new life.**”

“I have my youngest daughter back. She lives with me. My oldest daughter is getting married and my middle daughter is a college student.”
recovering survivors, it is important to build strong linkages between the treatment program and the local domestic violence / sexual assault service program.

Survivors with substance abusing partners may consider participating in 12-step or other support groups such as Al-Anon or Nar-Anon but the risks should be explored with the domestic violence advocate. Sometimes practicing detachment and avoiding enabling can lead to increased risk for harm if a partner is abusive. If a survivor is partnered with an abuser who is enrolled in a substance abuse treatment program, under no circumstances should they be asked to remove a protection order, no contact, or any other type of restraining order in order to support that partner’s recovery from substance abuse.

Additionally, survivors managing the effects of substance abuse should be encouraged to consider gender specific treatment as an option that may best enhance their chances for safety, reduction in harmful use, and/or sobriety. Since most substance abuse treatment programs were developed with men in mind, it can be really hard for people who identify as women, transgender, or gender non-conforming to find gender specific or gender relevant treatment. This is compounded when a person who identifies as a woman, transgender, or gender non-conforming is also a person of color, living with a disability, identifies as queer/lesbian/bisexual/gay, or experiences other identity-based, structural and social oppression. Options for gender and culturally relevant treatment options should all be explored and considered when referring survivors to substance abuse treatment or other services that support their path to safety, reduction in harmful use, sobriety, and wellness.

As domestic violence advocates, it is critical to educate local treatment providers about the philosophy and functions of advocacy-based counseling and the risks of domestic violence for people abusing substances. Survivors managing the effects of substance abuse might need the treatment provider and the domestic violence advocate to work together when strategizing for their safety, reduction in harmful use, or sobriety. Advocacy-based counseling looks different for survivors who have withdrawal issues, memory distortions and cognitive deficits, as well as warrants or Child Protective Services to deal with. Advocacy-based counseling may include: repeating information, providing structure, simplifying goals, advocating for their inclusion in shelters and other victim/survivor service programs, and understanding the impact of substances on safety planning and understanding your role as an advocate.

"I’ve gained more confidence in myself. I don’t have to run and hide in a closet anymore."

"Knowledge is power, knowledge is power."
Helping Survivors Develop a Plan

When asked to do so, help survivors develop a plan that will support their wishes for safety, reduction in harmful use, or sobriety. A plan may include, but not be limited to, some of the following:

- Identifying who to call for help (e.g., sponsor, counselor, support person, Alcohol and Drug Help Line), forming support systems, knowing about safe meetings;
- Knowing information and education about substance abuse, harm reduction, and treatment options;
- Removing substances and paraphernalia from the home;
- Recognizing unsafe people, places, things;
- Understanding how to deal with legal and other problems stemming from substance abuse (e.g., health, CPS involvement, poor nutrition);
- Assembling paperwork to determine eligibility for assistance or to begin seeking employment, school, housing, or other options;
- Knowing how domestic violence can be a relapse issue or contribute to an increase in use;
- Understanding physical, emotional, cognitive, environmental, and other cues indicative of risk and having a plan to deal with it; recognizing the role of stress and craving, and having a plan to deal with it;
- Learning how to parent, engaging in relationships, developing sober friendships; and
- Knowing when and where to run in a life-threatening situation that puts your safety and sobriety at risk.

Conclusion

Anyone can be at risk from domestic violence and substance abuse, but screening, identification, and intervention can provide empowering options. Anyone can also get safe, reduce harmful substance use, and sober and raise safe, healthy children. You can be a bridge to safety, reduction in use, and sobriety, and screen for substance abuse as part of a safety plan.
RESOURCES:

American Medical Association (1994). Diagnostic and treatment guidelines on domestic violence. Chicago, IL


*This intersection of issues is broadly understudied, underfunded, and undervalued, and many of these citations do not have more contemporary versions. The authors are pleased to receive any and all resources from readers of this article as they become available.

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Power and Control Wheel

POWER AND CONTROL

USING MALE PRIVILEGE
Treating her like a servant • making all the big decisions • acting like the "master of the castle" • being the one to define men's and women's roles

USING COERCION AND THREATS
Making and/or carrying out threats to do something to hurt her • threatening to leave her, to commit suicide, to report her to welfare • making her drop charges • making her do illegal things.

USING ECONOMIC ABUSE
Preventing her from getting or keeping a job • making her ask for money • giving her an allowance • taking her money • not letting her know about or have access to family income.

USING CHILDREN
Making her feel guilty about the children • using the children to relay messages • using visitation to harass her • threatening to take the children away.

USING ISOLATION
Controlling what she does, who she sees and talks to, what she reads, where she goes • limiting her outside involvement • using jealousy to justify actions.

USING MINIMIZING, DENYING AND BLAMING
Making light of the abuse and not taking her concerns about it seriously • saying the abuse didn't happen • shifting responsibility for abusive behavior • saying she caused it.

USING EMOTIONAL ABUSE
Putting her down • making her feel bad about herself • calling her names • making her think she's crazy • playing mind games • humiliating her • making her feel guilty.

USING INTIMIDATION
Making her afraid by using looks, actions, gestures • smashing things • destroying her property • abusing pets • displaying weapons.

DOMESTIC ABUSE INTERVENTION PROJECT
202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.duluth-model.org
**Power and Control Model for Women’s Substance Abuse**

**Using Threats and Psychological Abuse:**
Making and/or carrying out threats to do something to hurt her. Instilling fear. Using intimidation, harassment, destruction of pets and property. Making her drop charges. Making her do illegal things. Threatening to hurt her if she uses/does not use drugs.

**Using Emotional Abuse:**
Making her feel bad about herself, calling her names, making her think she’s crazy, playing mind games, humiliating her, putting her down and making her feel guilty for past drug use.

**Using Economic Abuse:**
Making or attempting to make her financially dependent. Preventing her from getting or keeping a job. Making her ask for money. Taking her money, welfare checks, pay checks. Forcing her to sell drugs.

**Using Physical Abuse:**
Inflicting or attempting to inflict physical injury by pushing, slapping, beating, choking, stabbing, shooting. Physically abusing her for getting high/not getting high.

**Using Isolation:**
Controlling what she does, who she sees and talks to, what she reads, where she goes. Limiting her outside involvement. Keeping her away from people supportive of her recovery. Preventing her from attending drug treatment and NA/AA meetings.

**Encouraging Drug Dependence:**
Introducing her to drugs, buying drugs for her, encouraging drug use and drug dependence.

**Using Sexual Abuse:**
Coercing or attempting to coerce her to do sexual things against her wishes. Marital or acquaintance rape. Physically attacking the sexual parts of her body. Treating her like a sex object. Forcing her to prostitute for drugs or drug money.

**Minimizing, Denying, and Blaming:**
Making light of the abuse and not taking her concerns seriously. Saying the abuse didn’t happen. Shifting responsibility for abusive behavior. Saying she caused the abuse with her drug use.

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202 East Superior Street
Duluth, MN 55802
218.722.4134

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Understanding and Responding to Men Who Batter Women with Disabilities
Scott Hampton, Psy.D. 2000

Significant strides have been made in improving our response to violence against women in many areas including health care, child protection and the workplace. It is equally important that we improve our response to violence against women with disabilities, due to the widespread abuse perpetrated against this population. Consider the following sample of statistics:

- Women with disabilities are more likely to experience abuse by a greater number of perpetrators and for longer periods than non-disabled women.¹
- 15,000 to 19,000 people with developmental disabilities are raped each year in the United States.²
- For individuals with psychiatric disabilities, the rate of violent criminal victimization including sexual assault was twice of that in the general population (8.2% vs. 3.1%).³
- Eighty-three percent of women with a disability will be sexually assaulted in their lifetime.⁴

To begin the discussion, we need a definition of “disability.” The Americans with Disabilities Act (“ADA,” 1990) defines disability to mean “a physical or mental impairment that substantially limits one or more of the major life activities of an individual.” Common examples of disabilities under this definition are mental retardation, confinement to a wheelchair, and sensory impairments such as blindness or deafness. Batterers define “disability” more broadly. To them, “disabled” is not only an adjective used to describe a group of people; it is also a goal of their abuse with any victim. In other words, batterers use a pattern of controlling behavior to “disable” their victims. Specifically, they seek to limit the ability of their victims to make independent choices. For those women who are already have disabilities (as defined by the ADA), batterers might view them as convenient or particularly vulnerable targets.

Batterers’ disabling behavior (that we refer to as domestic and sexual violence) can have devastating and widespread effects on the lives of women. The abuse can adversely affect the woman’s physical health, sexual and reproductive autonomy, psychological functioning, emotional welfare, financial independence, occupational or educational life, relationships with family or friends, connections with her religious community, and her ability to access social, health or legal services (see the diagram below).

Strategies that batterers use to create or exploit disabilities in several areas of victims’ lives
To assist victims of domestic violence with disabilities and to hold the batterer accountable for the harm they cause, we must understand the batterers’ motivation.

**Batterers seek women with disabilities.** Battering is the abuse of power to control an intimate partner. The more power the batterer has relative to his victim, the more effectively he can control her. To help ensure a significant power advantage, some batterers seek “disabled” women, who by definition are less “able” to protect themselves, especially from an abusive partner. He might also target women with disabilities hoping that these women will be more likely to long for the affections of a man who can be as charming as many batterers are on first impression.

**Batterers resent and punish women with disabilities.** On the one hand, a batterer might think that a woman with disabilities is less threatening than a woman without any disabilities. On the other hand, he resents her imperfections. He thinks he deserves to be with a woman who has more to offer. Consequently, he punishes her for having a disability. But the more hostile he becomes, the worse she feels about herself and the more likely that she wants to end the relationship. He can’t understand “how a woman with so little going for her could be so demanding” so he continues his attack on her self worth by saying something like “No man would ever want you with your disability. You should be grateful to have me.” This attack perpetuates a vicious cycle – the worse she feels about herself, the more hostile he becomes; the more hostile he becomes, the worse she feels about herself.

**Batterers “create” disabilities in women.** Many batterers fear that their victims will become independent and leave them. To reduce the probability of that happening, batterers try to impair their victims’ independence by manufacturing disabilities. For example, a batterer might seek to get his victim hooked on alcohol or other drugs, play mind games to make her doubt herself as a wife, or mother, or restrict her access to financial resources so that her ability to leave is compromised.

**Batterers create the perception of a disability.** Batterers cannot or will not tolerate their female partners’ independence, especially if that independence threatens their authority in the family. To maintain their power advantage, some batterers will try to convince family, friends or social services that she is flawed in some significant way. For example, he might try to make her appear to be an unfit mother by undermining her parenting or co-parenting. A common example involves batterers who claim that their ex-spouse is exhibiting “parental alienation syndrome” or “divorce-related malicious mother syndrome” even if she is only trying to protect her children from their abusive father. The fact that these “syndromes” have no scientific basis has not stopped batterers from citing them in custody battles as a way of “proving” that the mother of their children is suffering from a mental health disability and that he and his children are the ultimate victims of that disability. Unfortunately, this victim-blaming strategy has been successfully employed by many batterers and their attorneys.
Batterers exploit disabilities to separate their victims from social and legal services.
For batterers to effectively control their victims, they need allies to side with them against their victims. Perhaps nowhere have batterers been more successful in strengthening their alliances than against women with documented disabilities. For example, the batterer who takes his victim to her medical and social service appointments, makes it difficult for her to feel comfortable reporting his abuse. In addition, the women who are most vulnerable to domestic and sexual violence, are those society approves of the least. For example, lesbians, prostitutes and drug addicts are reluctant to seek assistance because of the way society shames them for being who they are.

Batterers justify their abusive control as a necessary response to disabilities. As firm believers in a patriarchal culture, batterers believe that they are entitled to control their female partners. They often cite the best of intentions, suggesting that they are “only doing it for her own good” and “because I love her so much.” He doesn’t want “to watch her make a mess of her life.” They believe that women with documented disabilities provide further justification for their authoritative use of control since “she needs me to make the important decisions for her.”

Batterers claim that their own disabilities caused them to abuse. “I only hit her because I was drunk.” “I lost control of my temper.” “My anger got the best of me.” “I was diagnosed with an impulse control problem.” “I forgot to take my medication for bipolar disorder.” All of these excuses for abuse are attempts by the batterer to convince us that he is not responsible for his own violence. He wants us to believe that he is as much a victim of his own disease, condition or disability as she is of his abusive behavior.

Batterers threaten to inflict disabilities. Battering tends to get progressively worse over time without intervention. Batterers escalate the frequency and severity of their violence in an attempt to maintain control and dominance over their victims. If they feel as though they are losing control, they may threaten to seriously hurt or even kill their victims or the victims’ children. Often, these are not idle threats, as evidenced by an alarmingly high rate of domestic homicide. 5

Recommendations:
To effectively meet the needs of domestic and sexual violence victims with disabilities, we need to evaluate the attitudes, policies and procedures of all relevant stakeholders. Following is a partial list of recommendations.

1. Consider “relative,” not just “categorical” disability. “Categorical” disabilities refer to those that are generally recognized as impairments (e.g., speech impediments, paralysis).

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5 On average, more than three women are murdered by their husbands or boyfriends in this country every day (Bureau of Justice Statistics Crime Data Brief. (2003). Intimate Partner Violence, 1993-2001.)
“Relative” disabilities refer to the power advantage that one person in a relationship has over the other person (e.g., batterers frequently are physically stronger than their victims and use that physical advantage for intimidation and control). Victims who are “categorically” disabled usually are also “relatively” disabled (when compared to the abuser). The concept of relative disability is also important when we consider the incidence of disabled adults who batter their non-disabled partners (e.g., a deaf man who batters his wife is “categorically” disabled but not “relatively” disabled when comparing his physical strength to that of his wife).

2. **Develop sensitivity to “circumstantial” disabilities.** Even people with no documented disabilities may have circumstances that make them particularly vulnerable to their abuser. For example, a pregnant woman, especially in the later stages of pregnancy, would have greater difficulty fleeing from her abuser or protecting herself than she would if she were not pregnant. Other “circumstantial” disabilities include language barriers, lack of education, job skills or social supports, and membership in oppressed groups based on racial, ethnic, sexual orientation, or religious affiliations. All of these and other “circumstantial” disabilities serve as barriers between victims and the services they need to become safe and autonomous.

3. **Explore your own attitudes regarding victims with disabilities.** It is not unusual to be afraid of, and shy away from, people who have obvious disabilities. The typical batterer wants us to be repulsed by his victim’s disabilities so that he can maintain his isolation of, and control over, her. For us to help victims of domestic violence with disabilities, we need to be aware of, and work through, our own feelings and reactions so that we don’t discourage those victims from coming forward. This is more difficult, though no less important, when we view the victim as responsible for her own disability (e.g., when she is a drug addict, rather than someone who was born with a disabling birth defect).

4. **Understand and challenge the batterers’ justifications for the abuse.** Batterers often cite their partners’ disabilities as an explanation for their abuse. A common example is the batterer who reported that “my wife has been diagnosed with bipolar disorder” to suggest that “if you had to live with my wife, you would do the same thing that I do.” These batterers want us to believe that the women’s deficiencies cause the men’s abusive behavior. We need to confront these justifications by teaching abusers that another person’s vulnerabilities are not an excuse for exploitation. Instead, they are opportunities for him to provide comfort. He needs to learn that we will no longer tolerate his abuse under any circumstance.
5. **Conduct routine screening for domestic and sexual violence.**
   Organizations that serve people with documented disabilities should, as part of their assessment and service delivery, screen for interpersonal violence. Since the caretaker could very well be the abuser, the staff employees need to use creative methods for interviewing their client without the caretaker present. Women’s crisis centers can help in developing effective interviewing strategies.

6. **Realize that in some cases, the abuser is the one with the disability.** Routine screening for interpersonal violence should also include questions to determine whether the caretaker is in need of services or protection. As one woman who was caring for her abusive visually impaired husband said, “I never thought I could ask for help. After all, who would believe that a blind man could hurt a woman with perfect sight? And I wanted to give him the benefit of the doubt, anyway. Maybe, if I did a better job of helping him, he wouldn’t get so frustrated with me.” When we discover a caretaker who has been abused, we need to be supportive and make the appropriate referrals for service.

7. **Victim service agencies need to conduct accessibility audits.** With the help of organizations that specifically serve the needs of the disabled, victim service agencies can identify, and develop plans to address, barriers that render their services inaccessible to some victims. Solutions may include the installation of a ramp to the front door of a shelter, purchase of a TTY phone machine so that a hotline can field calls from people with hearing disabilities, and audio recording of the agency’s brochures for those with limited reading ability.

8. **Develop meaningful relationships with other stakeholders.** Organizations that work with domestic and sexual violence victims and their families need to form collaborative alliances with the many organizations that address the needs of people with various disabilities. Such collaboration should include cross-training and referral, policy development, case conferencing, joint advocacy efforts and participation on each other’s advisory boards.

9. **Help the victim to develop an appropriate safety plan.** More women are seriously hurt, even killed when they attempt to leave their abuser, than when they stay. Consequently, we have learned not to tell battered women to “just leave” without a well-thought out and carefully timed safety plan. Attempting to flee a batterer, can be even more difficult and risky for a woman who has impaired mobility or other disabilities. In addition, safety planning is important, not just for victims who are attempting to leave, but also for those who are at least temporarily choosing to stay with the abuser.

10. **Focus on prevention efforts.** To make society safer for women with disabilities we need to change at least two cultural attitudes. First, we need to promote a consistent message that domestic and sexual
violence are always wrong, under any circumstance. No characteristic of victims justifies their being abused and no characteristic of abusers justifies their violence. Second, we need to remove the stigma attached to disabilities. People with disabilities are not second-class citizens with diminished rights. The fact is that we all have abilities and disabilities, strengths and weaknesses. We are all different, but we are all the same. We can celebrate the tremendous diversity among us, and be comforted with our even greater commonality. But at no point can we afford to view one group of us to be superior or more deserving than another.
ASSESSING NEEDS

While it is not necessary for advocates to become substance abuse counselors or mental health professionals, it is important to ask about all of the issues people we serve may be experiencing to ensure we are able to accommodate their needs.

However, timing is important. The intake and screening process for admitting people into your program should come first. Assess for multiple issues only after an individual has been admitted. Questions about multiple issues should never be part of the screening process. This section contains some helpful tips to make the intake and assessment process less painful, for both staff and the people you serve.

Reducing intake trauma

Most of our programs require that people receiving services complete an intake process. All intakes have a common thread, say Sonia D. Ferencik & Rachel Ramirez-Hammond in Trauma Informed Care: Best Practices and Protocols for Ohio’s Domestic Violence Programs:

“Intakes inquire about extensive, detailed, personal information on a subject that is very sensitive for most individuals. Some survivors find this process extremely painful, and there are many opportunities to trigger an individual or retraumatize someone seeking services.”

In their manual, Ferencik & Ramirez-Hammon (2011) offer several suggestions for making the intake process less stressful and intimidating for the people you serve:

Before you begin, describe what will occur during the intake process and why you need the information. Reassure individuals that they have the right to “put on the brakes” by asking to stop the process if any of the questions cause them to become triggered, exhausted, or in need of a physical or emotional break.

Inform individuals what you are writing down and why you are documenting what is shared with you. Also fully explain the release of information form and any other documents you are asking them to sign, and offer them plenty of time to read documents if they desire to do so before signing.

Explain the limits of your confidentiality before you begin, since this may impact which issues an individual feels safe sharing with you. Clarify to survivors what information you cannot keep confidential due to ethical,
professional, or legal obligations. This often includes information about imminent harm to a child or credible threats to hurt another individual or oneself.

Intake questions are often shaped around grant reporting requirements and require lots of information that may seem unnecessary and even insensitive to a survivor in crisis. Remember this and have empathy for the feelings survivors have about the process.

Include survivors in deciding when to complete their intake. Individuals may feel much better about answering needed questions once they have had a chance to get themselves and/or children settled.

Pay attention to the environment. Is the space where you are doing the intake interview quiet and private, or are you constantly interrupted by others or have people passing by in the background? Do you have tissues and water available? Allow the individual to modify the lighting and perhaps even offer quiet music as an option. Offering water, tea or coffee and a choice of snacks during the intake can also help put the individual at ease.

When concluding the intake process, ask how the individual is feeling. Make sure you are not letting the person leave feeling vulnerable. Questions to check out include: How are they feeling both physically and emotionally? Do they have any questions they wanted to ask?

(See our Appendix: Additional Resources, for information about the manual Trauma Informed Care: Best Practices and Protocols for Ohio’s Domestic Violence Programs, and how to get a copy.)

Performing a needs assessment

A needs assessment can be a nonthreatening way to glean information about additional issues that may need intervention or referrals. The goal of a needs assessment is to ascertain ways your program can better serve and accommodate an individual rather than to screen a person in or out of the program. When conducting the assessment:

The needs assessment should be done after individuals have been admitted to your program. Emphasize that the assessment will have no impact on shelter status or ability to stay in the program.

“Normalize” questions and find a way to discuss co-occurring issues that is comfortable for both of you. “Normalize” responses to traumatic situations, rather than pathologize the individual (Ferencik & Ramirez-Hammon, 2011).
Allow people who seek our services to tell us what they need and when, rather than assuming the “expert” role and telling them what they need. “When you’re working with people, allow them to take the lead,” says Olga Trujillo, Director of Programs at Casa de Esperanza in St. Paul, MN. “So when they come to you, they might be in a place to be able to deal with a certain issue, or they may not be in a place to be able to deal with it. They might just need crisis management. Or they might need something more than that. And they’re going to let you know” (Trujillo, 2009).

Ensure that people impacted by both interpersonal violence and other complex issues know about available resources. Explore options such as transitional housing, counseling, gender specific substance abuse treatment, support groups addressing multiple problems, children’s services, safety planning, and linkage to other providers.

If lack of appropriate training or credentials prevents you from answering a question or providing a certain kind of assistance, explain this to the individual seeking your help. Make it clear you will help them figure out who can provide the needed help and are happy to explore options with them.

Use an interpreter when necessary. However, avoid using children, relatives of the abuser, or people who do not understand confidentiality and domestic violence, sexual abuse, and stalking issues.

An individual’s decision to decline treatment, advocacy, shelter, or other services should not be viewed as failure. Supporting people through their process of change requires an understanding that motivation comes from within. Making changes is both an option and a process that can take time.

Understand the courage required to seek services. Convey to the people you serve that you appreciate their courage: “With all the stuff that’s going on for you, you still managed to do this. That’s fantastic” (Obtinario, 2010).

**How do we ask those “sticky” questions?**

Advocates and other providers are sometimes reluctant to ask about certain issues, lest they offend the people who come to them for help. Substance abuse may feel like a particularly touchy topic – especially if activities such as sex trafficking or illegal drug use are involved. Asking about mental health concerns or suicide risk may also feel tricky, and providers may fear risking legal problems if they ask about disability issues.

However, advocates may miss countless intervention opportunities if they are afraid to ask the important questions (Bland, 2001). And asking the right questions can even be life-saving. For example, advocates should always
assess for suicide risk or potential for other self-harm (Pease, 2010).

The intervention is in the asking (Bland, 2001). Fortunately, there are respectful ways to raise sticky issues. Please note: These questions should NEVER be part of the initial screening process. Only ask these questions AFTER the decision has been made to admit a person into your program.

Regarding substance abuse, Cindy Obtinario, a chemical dependency/domestic violence specialist with New Beginnings in Seattle, WA, says: “The way we frame this questioning process is, ‘We are asking for this information not to screen you out, but to help support you in seeking safety, and to be able to give you the best referrals possible’” (Obtinario, 2010). 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 concerns, or other personal issues. Asking open-ended questions can be helpful:

“What has worked well for you and what has given you problems?”

“Many people tell me a little alcohol helps take the edge off stress. How often has this worked for you?”

As another example, Farley (2003) stresses the need for questions regarding a history of exploitation by the sex industry. Unless screening questions such as these are asked, she says, this type of victimization will remain invisible. Questions she suggests include:

“Have you ever exchanged sex for money or clothes, food, housing, or drugs?”

“Have you ever worked in the commercial sex industry: for example, dancing, escort, massage, prostitution, pornography, phone sex?”

While asking people with disabilities a question such as “Do you have special needs we should be aware of?” may feel disempowering, a more general question would be appropriate to ask anyone seeking services, whether they have a disability or not (Leal-Covey, 2011). Examples of general questions would include:

“Would you let me know if you need anything?”

“Please feel comfortable asking if you need anything.”

If the individual has been a target for oppression due to misconceptions about race, culture, sexual orientation, disability, or other status, consider how these other oppressions impact the experience of trauma and access to services.
Also consider how the individual’s cultural background may have been a source of support. Questions suggested by Ferencik & Ramirez-Hammond (2011) include:

“What has worked for you in the past?”

“What has helped you within your culture and family of origin?”

Here are some additional examples of questions you can ask to better accommodate individuals participating in your program.

**Sample framing questions about abuse:**

“Women often report feeling stress in their relationship. How does your partner show disapproval?”

“Please describe any threats made by your partner. (How often? When was the last time? Were you afraid? Were you hurt? Can you tell me what happened?)”

**Sample framing statements:**

“Domestic violence and sexual assault are major problems for women. Because abuse is such a common experience for women, I ask everyone I see whether they feel safe.”

“Women in treatment often tell me their partners complain about their using. How does your partner show disapproval?”

**Sample indirect questions:**

“You mentioned your partner loses their temper with the kids. Can you tell me more about that? Have you ever felt afraid for yourself or your children? Can you tell me more about that?”

“All couples argue sometimes. Does your partner’s physical or sexual behavior ever frighten you?”

**Sample questions if partner is user or abuser:**

“Many survivors tell me their partners don’t want to drink/drug/smoke alone. How often do you find yourself using when you don’t really want to?”
"When a partner spends family money on drug use, it is a form of economic abuse. Has your partner ever used food or rent money to drink or score drugs?"

Sample framing questions for substance abuse:

“People I see often tell me they feel stress. There are several ways to deal with stress. What works best for you?"

“Many survivors tell me they try to sleep more, eat better, or shop for baby things. Have you tried any of those ways of coping?"

“Many survivors also tell me the best way to cope is to smoke a cigarette, have a drink or take something else. How often has that worked for you? Do you find it is still working?”

“Being involved in a court case/custody dispute can be stressful. Your partner may attempt to undermine you/your parenting skills. Can you identify any reasons why drinking or using drugs right now could be harmful to your case? Can you share with me what your partner might say about your drinking or drug use?”

Remember to ask direct questions tactfully and respectfully! These questions may help advocates and other providers identify accommodation needs for individuals using services. Answers to these questions are NOT used to screen people out. They are provided to help survivors address safety or health risks stemming from multiple abuse issues. While advocates and other providers may hesitate to ask “taboo” questions because they fear giving offense, for many people seeking help, these same questions can send a positive message:

“It’s safe to talk about this issue here.”

When people are respectfully asked about substance use, mental health concerns, and other issues that may impact their safety, they hear your message, even if they are not ready to enact change immediately. Often individuals will later share comments such as, “You know, when you said __, it really made sense to me” (Bland, 2001).

Follow-up questions to enhance service provision for all

Questionnaires such as CAGE Questions, The 4 P’s, Emotional Well-Being: Sample Questions to Ensure Better Accommodation and Where Can I Get Help? (all available for download from the Web version of Real Tools:
Responding to Multi-Abuse Trauma) can help advocates and the people you serve to assess what kinds of assistance and referrals are wanted or needed. Use these questionnaires to assess needs ONLY, not to screen people in or out of your program. When using these forms and questionnaires, keep in mind:

Information derived using these tools should not be placed in an individual’s file due to the sensitive nature of the information to be discussed and confidentiality concerns.

Do not make assumptions about the people you serve. These questions should be addressed with everyone, to determine how we can best accommodate them.

These tools should never be used as screening tools at intake.

Using these tools to withhold services – that is, to screen people out – would be a violation of both the Americans with Disabilities Act and Fair Housing regulations.

Once needs have been determined, give the Where Can I Get Help? form to the individual with the appropriate referrals and contact information filled in.

If your agency offers support groups, you may wish to use the Where Can I Get Help? form as the basis for a general group discussion of resources available in the community. The group facilitator might ask, “Where would a person go who needs rental assistance?” “Where would someone go who needs a bus pass?” And so on. Then have the group fill out the form as a group activity.
References


Women Talk About Substance Abuse and Violence

The following are detailed accounts of domestic violence and substance use and abuse.

Ten women were interviewed about their experiences with substance abuse and violence. All 10 were survivors of some form of abuse: battering, rape or sexual assault, incest or child sexual abuse. In addition to the violence, all of them had experience with alcohol or drug abuse, either on their own part, on the part of their partner, or both.

At the time of the interviews, all of the women had left their abusive relationships, and those with chemical dependency problems were in recovery. They talked frankly about the impact of the substance abuse on their efforts to escape the violence and heal from abuse. They also discussed the ways in which their experiences with violence affected their efforts to recover from alcohol or other drug addiction.

Q: What was your experience with physical or sexual abuse?

A: I was in my abusive relationship for 16 years. I couldn’t eat or sleep or go to the bathroom without permission. I was beaten. I was repeatedly raped. I had guns in my ears, guns down my throat, guns at my neck, guns at my stomach. I couldn’t tell anyone the truth because he said he’d kill me. I knew he would.

A: Our third date he moved in with me. And about a week later he punched me upside the head and knocked me out of a chair. One night he dragged me out of bed cause I wouldn’t give him any money and beat me up. I said no one time and that was it. He just started beating me. Just cause I said no.

A: After six weeks of dating, this man tried to strangle me.

A: I was a 17-year-old unwed mother and 2 days after I found out I was pregnant, he made me pull the car over and when I got out of the car, he hit me with his fist in the stomach.

A: He raped me. And when the kids came home from school, he bought them a pizza. We all had pizza. He could come home and rape me, order a pizza like nothing happened.

A: I was sexually abused when I was 5 years old. He fondled me and I fondled him. I knew that something was wrong. He said not to tell anybody.
A: I had incest in my life. I remember being in my mother and father’s bedroom. And I remember feeling real physical harm inside. I had severe vaginal pain. I don’t know how long that went on, but I do know it all happened before I was 8 years old.

Q: What were your personal experiences with alcohol or drug use?

A: When I was a little kid, we all got shots of whiskey. And I loved it. You got that warm feeling and everything was going to be okay.

A: For as far as I can remember, I’ve had some sort of substance in me. I started using drugs when I was 10 years old.

A: I had my own little chair in a closet and I’d go sit in there, just me and my bong.

A: We used marijuana every day. I did a lot of cocaine. When I used cocaine, all I wanted to do was that next line. I didn’t care about putting the kids on the bus or getting the kids to school. I lost my children.

A: I was a blackout drinker from the age of 15. My alcoholism was sitting home sipping wine all day. I could sip the whole gallon. I thought I was crazy. Not really thinking, well, it’s the alcohol.

A: One day I didn’t want to drink and I had to. It was the scariest feeling. I got the shakes. I was real nervous, and I knew a drink would fix that.

Q: Did you see your substance abuse and woman abuse as being connected in any way? For example, did you drink or use drugs to help you cope with your feelings about the woman abuse?

A: Whenever he’d get really angry and the fights would start, it was easier for me to just go in the back bedroom and get stoned and try to put it all away.

A: For me, the substance abuse when I first started using was over abuse, was over a rape, and so that’s how I learned to cope with any type of abuse was to get high, and it made everything okay.

A: I was darned lonely. I had no friends. I had nobody to talk to. So I started smoking more, getting high more often, with every aspect of the abuse, between the isolation, the physical abuse, the sexual abuse. This way, I didn’t feel any pain. I didn’t feel any guilt. I didn’t feel anything. I didn’t want to feel.
A: I just didn’t want to be conscious of my actions or his actions.

A: All I know is, when I was being abused, all I wanted was more and more. The marijuana wasn’t enough. Then I started getting into the crack. It was easier just to stay stoned and numb and not have to deal with it. The drugs were what made me forget about all the abuse and set aside the fear and the terror I had from the abuse and that was my only escape. It was a way to get away from my husband and not feel trapped.

A: I’ve known for 10 years that I had a serious problem with drug use but I was not willing to give it up because that was my way of coping. The drug didn’t hurt as bad as reality hurt.

**Q: Did your partner abuse alcohol or other drugs? If so, did you see a connection between his substance abuse and the violence?**

A: The basement was off-limits to me. I was never allowed in the basement. He was a drug addict and that was where he kept most of his drugs.

A: He drank, and he used marijuana heavily. He also used other drugs. The abuse kept going. Not even just when he drank. I mean stressful times. He really hurt me, and I remember just laying, pregnant, in a ball, sobbing, as he just drank himself into oblivion.

A: The abuse escalated, especially when he was coming down from coke, or if he had a hangover from coke.

A: He was violent when he wasn’t drinking, but he was more violent when he was drinking. Any little thing would set him off. He’d wake up and want more alcohol. And then the cycle would start all over. I kept thinking in my heart that if he’d only quit drinking, then life would be a lot better. I’ve come to the understanding that a person is going to drink or not drink. It’s their choice.

A: If you sober up a perpetrator and he doesn’t have treatment for his issues, then what do you have? You have a sober perpetrator. And now he’s more aware.

**Q: Did you find that substance abuse got in the way of your efforts to cope with the battering or heal from other forms of abuse?**

A: It got in the way a lot. I left the shelter because he bought a bag of cocaine. And so, here I was back in the same abusive relationship all over again. I wanted to be strong, and even though I wanted to be out of an abusive relationship, my addictions took me back.
A: I didn’t have time to heal. Because every time you drink, then there’s no emotional growth. Or you just start to look at an issue like alcoholism or domestic violence. You just start to look at the sexual assault and it’s too painful. You drink to numb the pain. So it never really goes away. It’s never dealt with. It just gets under the rug, and it resurfaces again and again.

A: It made it certainly harder for me to cope.

A: I first went looking for help to get away from the abuse. While I was in shelter, one of the things they very strongly enforced was no alcohol or drugs. And I was having a real hard time with the no drugs. So my pipe and all my goods and stuff stayed in my car. I’d get in my car and go down a couple of blocks, sit in a Safeway parking lot and get stoned.

A: The drugs are an element of control. If they can keep you on the drugs, using or addicted to the drugs, they’re in control. And it’s like strings on a puppet. They just keep you under control because you want that other hit. You want that other drink.

A: And drinking kept me in the relationship longer. When you’re drinking and you’re in that vicious circle, the other vicious circle doesn’t matter. All I cared about was getting another drink.

A: Because of my drug use, I would not accept or see the violence. My head’s not clear enough, or wasn’t clear enough, to see the reality of the situation.

A: For me, once I pick up the alcohol or the other substances, it’s like that safety plan goes out the window.

A: It kept me isolated, so I stayed at home in my room with the curtains drawn. On top of him keeping me isolated and not allowing me to go anywhere. But I think the biggest thing it did was kept me from getting out and getting that help I needed. Now, being clean and sober, I know it’s so much easier for me to tap those resources.

**Q: Did you find battering or other abuse got in the way of your efforts to recover from substance abuse? Was this ever a relapse issue?**

A: Every time I thought about getting into a new relationship, I just wanted to drink.

A: I think the underlying shame that I felt, and not dealing with the sexual assaults. I didn’t see that at first when I got sober. The connection didn’t become clear to me until I’d been in recovery for some time.
A: Not being able to go to meetings. Not being able to get out around people who were sober.

A: Going to a meeting wouldn’t be anything he would tolerate because there would be other men there. Something could happen. So his controlling made it real difficult for me to do what I needed to do for myself.

A: I made it for 30 days. The minute I got out of the safe environment I was right back with the man and by midnight, using.

A: I believe I needed more than just a 12-step program.

A: You can talk about all these wonderful spiritual things, but if you don’t have any food and you don’t know where you’re going to sleep, and you’re running for your life, you don’t have time for any of that stuff. You’re just stuck on survival.

A: This man tried to strangle me. After that happened, then I relapsed. And I was in relapse mode off and on for a whole year after that.

A: I think when you stop denying things that have happened in your life in the beginning, all that from the incest, then you can stop the denying of things that happened a couple of years ago. Sick relationships and the drug abuse, and the self-destruction. I think from that point on, I could start to recover.

Q: Did you get any messages from others that you were to blame for battering or other abuse?

A: Yes, I got that message from family, friends and my abuser. It was always my fault.

A: He said I was ugly. He said I was a bad wife. He said I was an unfit mother.

A: Well I told you to shut up and you wouldn’t shut up. Or all you had to do was make me bacon. Or I didn’t hit you that hard.

A: I chose to marry a man from the other side of the tracks. Deal with it.

A: My parents and my family, they liked him. They said it was my fault he started drinking, because I was nagging him. I wasn’t treating him right. That was the reason he broke my face, broke my nose, broke my jaws. I was doing something to cause him to hit me. It was my fault.

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Q: Did you believe this yourself?

A: He told me it was my fault that he hurt me. And I believed him. After all, he didn’t rage at anyone else, and he didn’t hit anyone else but me.

A: It just whittled away. I was told regularly if you hadn’t done this, then I wouldn’t have done that. Over a long period of time to the point where I thought I was crazy. And I really started to believe, if I act just right, I can keep this from happening to me.

A: Part of his abuse was brainwashing, and he was very good at it.

Q: Did you get any messages from others that you were to blame for battering, sexual assault or other abuse because of your drinking or drug use?

A: He was always saying the reason he would abuse me was because of my drug use, even though he had his drug use that was not a problem, or he would bring the drugs to me.

A: He would not admit that he was abusing me. But he was like, you did the drugs. You deserve to get your ass kicked. My mom always took his side. She was aware of my marijuana use and my cocaine use, and she’d be like, what man is going to put up with the things you do? And I got that from a lot of people. All the time it was, I deserved it because I wasn’t being a good mom, I was using drugs, running around to taverns and staying up all night, and sleeping all day. Oh, yeah. Big messages.

A: I had been raped, gang raped, when I was 17 and I had been using. I didn’t even realize it was rape until a woman pointed that out to me. She said any time you have sex without your consent it’s a form of rape. I think that the attitude about women, if you hadn’t put yourself in that situation then that wouldn’t have happened to you. What did you expect?

Q: Did you believe these messages yourself?

A: Yeah, I believed it for a long time. He kept telling me I was the one who was insane, and that I was always going to be that way as long as I used the drugs. So it was my fault that I made him angry. When I’d really get into the crack I would get to the point where I’d get suicidal. And then it was him not being able to cope with my mood changes and stuff like that.

Q: When you tried to seek help for the violence, did you run into any problems? How did people respond?
A: The cops would come and they’d say, you’ve been together how many years? Get over it. Kiss and make up.

A: We come from a very small town, and when I got my divorce, the judge told me, we do not mention the words domestic violence in this courtroom.

A: The first time he tried to kill me, we went and saw a psychiatrist, family counseling, and I actually did kick him out of the house. The psychiatrist wanted him back in the house, told us we should be able to work it out.

A: I went to the church and told them that I was in fear for my life, and if somebody would just go with me from the church, I could get my cat and I could get my belongings. People in the congregation patted me on the head and told me, “Oh, it’s okay.” Denying that there was any abuse going on. It made me turn my back on my faith.

A: People tend to look the other way. It’s just not something they want to see. It’s denial.

**Q: Were there any personal barriers that stood in the way of your getting help for the battering or sexual abuse?**

A: I never thought I’d have the strength to leave. I never knew I could. I didn’t have the resources that we have now. I did not know domestic violence was against the law. I had absolutely no idea.

A: I was afraid of what life would be like alone, big time. Of the mom thing. Three children. And so finances kept me there too. I thought the only thing to do was to stay and keep on doing what I was doing. You know, domestic violence is barely out in society now. Until the police told me about the battered women’s shelter, I didn’t know there was help, and I think I was pretty unaware of substance abuse help too. I just didn’t know.

**Q: What kept you from getting help for the substance abuse?**

A: The feeling of isolation both being a female alcoholic, that internalized shame, and then the internalized shame I had from the domestic violence.

A: Pretty much what people would think was the biggest thing. The shame pretty much kept me from getting any kind of help that I needed. I just stayed addicted.
A: I thought alcoholics were people in the gutters, the winos pushing their shopping carts with all their belongings in it. And I figured since I had a job, a car, the whole nine yards, that I was doing pretty good.

A: I didn’t think marijuana was addictive.

A: How do you get up in the morning and not smoke a joint?

A: And denial is an awesome thing. It truly is. If you don’t want to see it, or you can’t handle it, then it simply is not happening.

Q: When you were trying to recover, did your partner ever try to put roadblocks in your way?

A: Oh yeah. Because it was really tough for me when I first quit. It was difficult the first 30, 60 days. When I talked to him on the phone, he’d always tell me, all you’ve got to do is tell me babe, and I’ll go get you some more. He kept telling me that that’s all I needed was a couple of bong hits or a couple of rocks and I’d be just fine.

A: I got clean and sober and started working, and putting money away to get out of the relationship. And I think he saw that. He became more demanding. Attempts to be controlling escalated. His abuse of the kids escalated as I was sober. His attempts seemed more desperate.

Q: What finally led you to get help for the woman abuse?

A: This man was just physically beating me up. My middle daughter was between us a lot of times, and while she was standing between us, he would reach around her and pull my hair. I walked into her bedroom to check on her, and she was hiding underneath the bed. I realized he was affecting the kids.

A: The nice periods were shorter and shorter, and the abuse got longer and longer. Just couldn’t take it anymore.

A: When I was using, I didn’t have the ability to reach out for help, nor did I feel I needed it. Not using made me feel again, and when I felt again, I knew I needed help, because the pain was there. And that’s when I reached out. If I would continue using, I would never have reached out.

Q: What led you to get help for the substance abuse?

A: The choice of either stop using or live on the street. At this time, I was
smoking crack cocaine. Because I was so devastated by the use of it, I just wanted to be really free from it.

A: Once I walked away from that abuse [violence], I knew the next thing I had to do was do something about the substance abuse. And then, when I made up my mind that I wanted to quit the drugs also, the advocates at the shelter were right there for me, and got me into a treatment program.

**Q: Do you think it’s important to address both violence and substance abuse together?**

A: I don’t think I could deal with one issue alone. It was critical that I deal with the domestic violence, to get away from it, because it was just getting worse and worse. But I couldn’t deal with the domestic violence if I was still getting all drugged up.

A: You’ve got to be sober, at least a little bit, to be able to even look at the domestic violence. But if you get sober, and you don’t look at those issues, you’re not going to stay sober, not in the long run.

A: I couldn’t recover from substance abuse if I was still being physically abused, mentally abused, because I would be right back to using. So they walk hand in hand. I would not recover from one unless I address the other, and vice versa.

A: Without being clean, I can’t deal with the abuse issues, and without dealing with the abuse issues, I’ll just go back to using.

A: Getting off the chemicals has made it much easier for me now to deal with the other situations I need to in order to get back on my feet.

**Q: What has been most helpful to you in addressing both the substance abuse and the woman abuse?**

A: I’m going to a domestic violence group that also addresses chemical dependency issues. The domestic violence and drug abuse have very similar qualities.

A: You have the minimizing. The denial. All that stuff that goes on with the chemical dependency, you have with domestic violence too.

A: I get a lot of support on both issues this time around.
A: Accepting suggestions and help from other people. Being clean and sober and seeing the potentials that I have.

A: Staying clean and being able to talk about what’s going on really helps.

A: It helps to see that you aren’t the only one. And that someone else did make it. And someone else has made a life for themselves.

A: They try to make you feel that you’re not worthless or useless.

A: Somebody wanted to show me support, listen to me, not yell at me, not scream at me, just look at some options instead of that. Through them showing love to me, I began to love myself. I didn’t deserve the punishment I was giving myself for all that had happened in my life. The continuous bad relationships, continuous abusing the drugs, and shame and the guilt I felt from all that. I deserved better. It was also OK to heal from all that.

A: The longer you’re clean, the more you talk about it, the easier it gets. And it feels in the beginning like it’s the end of the world, but it’s actually the beginning of a new life.

**Q: What has been your experience with support groups? Have you been encouraged to talk about both issues? How do you handle this?**

A: I have a sponsor in a 12-Step program. And she is both a survivor of domestic violence, and in recovery for 14 years.

A: I’m very determined to live a violence-drug free life, so regardless of what kind of meeting I go to, I talk about what I feel I need to talk about. Anytime I talk about my domestic violence, I’m also speaking on my chemical dependency. I go to groups and I say what I feel I need to say. The meetings I go to deal with both.

A: For domestic violence survivors, women’s meetings are probably safer.

A: Where it was safe to talk about both the chemical dependency and the domestic violence.

A: Especially with other women who have both issues, those who know the abuse, all aspects of the abuse.

A: The more you tell your story, the more you talk about what you did to get clean and sober, the stronger it makes you the more you hear it. And the longer we’re away from the abuser, and the more education that we get,
and the more we talk to other people about it, the stronger we become and the more aware.

**Q: Many women have mentioned problems they encountered when they first tried to seek help. Have you done anything personally to try and change attitudes about chemical dependency or violence against women?**

A: Being a sponsor in the A.A. program. Just talking with some of the new people that are coming in.

A: Just sharing it with other people in the meetings, my experience of how I am now, compared to where I was when I first realized I needed to start doing something about the problems.

A: When I’m helping other people, it’s keeping me conscious of where I’m at in my program and what I’m doing to take the steps to keep myself clean and sober.

A: Because of all the stuff that I’ve been through, with personal journeys, the law, and the police and the court system, I want to get involved in effecting change.

A: Working with other addicts and abused women and homeless women, that’s my healing every day. A: And put DV information everywhere. I have put it everywhere I can think of. I’ve got it in the schools, in the libraries, in the grocery stores, in the movie theaters, in the dentist office, in the car dealerships, in the tourist information centers. You name it, I put it there.

**Q: What would you say is the best thing about being both safe and sober today?**

A: I’ve gained more confidence in myself and learned so much more about myself. It’s still lonely. It’s still quiet. But it’s better than being drugged up and arguing and fighting all the time. I don’t have to run and hide in a closet anymore.

A: I have my youngest daughter back. She lives with me. My oldest daughter is getting married, and my middle daughter is a college student. I was blessed with talking to 3,000 teenagers this fall at the convention center. No line of cocaine, no reefer, no drugs, no man, ever brought me to the feeling of being able to talk to those children.

A: I’m able to have clear thoughts. I have a sense of reality. I’m not easily swayed. It’s easier for me to pick out unsafe situations and unsafe people.
By being sober, I’m more aware of what’s going on around me. I don’t have to be in another abusive relationship and I don’t have to let people treat me like that.

A: I’m a pretty intelligent person, and I never realized that. I never realized how really intelligent I was.

A: I am my own advocate, I realized.

A: I have a lot of women friends and I’ve never had women friends. Never.

A: I wouldn’t trade where I’m at right now. I remember that feeling. I remember the withdrawals. I remember the cocaine dreams too vividly. Nightmares. Don’t want to go back. Ever.

A: I am, for the first time in my 41 years dealing with life on life’s terms without somebody telling me how to do it. I can actually talk to people now without being drunk. I can actually laugh without being high. And I can actually walk out a door without being paranoid. That feels good. That feels so good. Because I want to live.

**Q: What would you tell other women who are experiencing substance abuse and violence?**

A: That you can get out of an abusive relationship. That you can recover. That you’re not alone.

A: No relationship is better than an abusive relationship.

A: And I don’t think women should feel they need to make a man happy. That’s a two-way street. A: Just taking even baby steps toward asking for help. That was the biggest and most difficult thing for me to do.

A: It’s hard picking up the phone, but both problems have hotline numbers. And once you do it, it just gets easier after that. And if you don’t get help, it just gets worse. A lot worse. Both issues.

A: Please reach out. Talk to a peer. Talk to somebody you can talk to.

A: I can’t go back. I can’t truly ever return to that state of denial. I know too much now. A: Knowledge is power. ... Knowledge is power.

*Based on interviews conducted by Debi S. Edmund and Patricia J. Bland in Springfield, IL, and Seattle, WA.*

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Understanding Survivors Experiencing a Substance Use Disorder

By Patricia J. Bland, MA CDP

Survivors suffering from a substance use disorder (SUD) don’t know when they have the first drink or take the first drug what the future will hold. They expect to ‘feel better’ or ‘kill pain’ and find themselves believing they can ‘control’ it. Unfortunately, a substance use disorder generally leads to loss of control and powerlessness.

This loss of control and powerlessness does not mean one is weak or helpless. Instead, those who experience a SUD cannot reasonably predict what will happen when they use due to bio/psycho/socio factors including liver function and brain chemistry. One is powerless only in terms of how one’s liver, one’s body and one’s brain respond once substances are present.

Many survivors experiencing a SUD want to stop using alcohol or drugs. They want the craving, the problems and the pain of withdrawal to stop. They want to be like everybody else who can have a social drink or take medication without complex, serious ramifications.

Unfortunately, like anyone else discovering an allergy (e.g., an allergy to bee stings), a person experiencing a substance use disorder, once “stung,” may forever need to avoid substances or experience life-threatening health consequences. Fortunately, we can support survivors’ empowerment through our knowledge of options and available resources.

Safety and sobriety can be addressed in a respectful, trauma-informed way if we acknowledge both substance use (e.g., a glass of wine with dinner), and being in an intimate relationship (e.g., dating or having a partner) is a common experience both for survivors we serve and for us as advocates. This means misuse of substances or abuse within an intimate relationship could happen to anyone. This being the case, anyone could find oneself having a problem with substances or a partner through no fault of their own. (Bland, 2008)

People experiencing a substance use disorder are often unfairly blamed for having a brain disease. A major symptom of this disability is to believe one does not have a problem. This belief plus social acceptance of drinking or taking medication to kill pain can make it hard for survivors to seek help.

Batterers often choose to coerce their partners to use substances, prevent treatment, sabotage recovery, and benefit from a lack of services for people experiencing both DV/SA and addiction. This is an often overlooked form of physical and emotional violence AND a method of exerting power and control. As advocates, we must remember, batterers pose a threat to both safety and recovery for survivors affected by both DV/SA and substance use. While withdrawal symptoms and overdose can be dangerous, a SUD is treatable and long-term recovery IS possible particularly when safety is assured (Bland, 2008).

Sorting Out Messages

If you are recovering from an addiction, you may be seeing a substance abuse counselor. If you are dealing with violence or abuse, you may be seeing a women’s advocate. If you are seeing a women’s advocate and a substance abuse counselor, you may be getting confused! These are some of the messages you may be hearing:

**Substance abuse counselor:** You have a disease. You need treatment.

**Women’s advocate:** You are a victim of a crime. You need justice.

**Substance abuse counselor:** Your priority must be sobriety.

**Women’s advocate:** Our priority is your safety.

**Substance abuse counselor:** You must accept your powerlessness.

**Women’s advocate:** You need to be empowered.

**Substance abuse counselor:** You need to look for your part in your problems.

**Women’s advocate:** You are not responsible for what happened. The perpetrator must be held accountable.

**Substance abuse counselor:** You need to change yourself and be of service to others.

**Women’s advocate:** We need to change society.

Can these statements all be true? One way to reconcile the messages is to understand that substance abuse and violence are different problems. When people talk about different problems, they may need different words and different approaches. Here are some examples.

**Disease or criminal behavior?**

Addiction is a disease. It is not a crime. People do not choose how their bodies will respond to alcohol or drugs. People with addictions deserve treatment and recovery. Violence is a crime. It is not a disease. Perpetrators choose to commit domestic violence, sexual assault and sexual abuse. Their victims deserve justice.

**Safety first or sobriety first?**

For “recovering survivors,” both safety and sobriety must be priorities. Women’s advocates have clients develop a safety plan. Substance abuse counselors have clients develop a recovery plan. You can make recovery part of your safety plan, and safety part of your recovery plan.

**Powerlessness or empowerment?**

You are powerless over the impact of chemicals on your body. You are powerless over another person’s behavior. But you can choose to seek help getting safe and sober. When you make personal choices, you become empowered.
**Who is responsible?**
You are responsible for recovery from addiction. The perpetrator is responsible for violence. You are responsible for your own choices and your own behavior. You are not responsible for another person’s choices or behavior.

**Social change or service to others?**
Service to others is one way to achieve social change. Working for social change can be a way to serve others. When people in 12-Step groups take a meeting to a jail or hospital, they serve others. They also create social change by making recovery available to more people. When abuse survivors make a T-shirt for the Clothesline Project, they help change public attitudes about violence. This serves other victims of violence.

Of course, sometimes the same approach can work for different problems. People with addictions often take a “one day at a time” approach to recovery. This approach can also work well for women leaving a violent relationship or healing from abuse. Both recovering women and abused women can benefit by getting support from others.

When sorting out messages from helping professionals, be creative. Give yourself permission to reconcile the messages in a way that works for you. The most important thing is that you be able to benefit from both kinds of services.

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Some examples of the differing words and approaches used by women’s advocates and substance abuse counselors are adapted from *Domestic Violence and Chemical Dependency: Different Languages*, developed by Theresa Zubretsky, New York State Office for the Prevention of Domestic Violence. Available: [www.thesafetyzone.org/alcohol/language.html](http://www.thesafetyzone.org/alcohol/language.html)
Woman Abuse, Substance Abuse: What is the Relationship?

When substance abuse and violence against women happen together, many people get confused about cause and effect. Does alcohol or drug use cause a perpetrator to get violent? Does being a victim of violence cause a woman to develop substance abuse problems? If a woman abuses alcohol or drugs, does this mean she asks for trouble? Here, based on research, are answers to some commonly asked questions.

*Does alcohol or drug use cause violent behavior?*

Studies show that people who get violent when intoxicated already have attitudes that support violence.\(^1\) They believe they have the right to control another person. They believe violence and other abuse are acceptable ways to gain control. A perpetrator may use intoxication to excuse violent or abusive behavior. But substance abuse is no excuse for crimes such as domestic violence or sexual assault.

*Will treatment help a perpetrator stop being violent?*

If a woman leaves an abusive relationship, her partner may promise to get treatment or attend A.A. meetings. These promises may be a way to manipulate her into returning. Unfortunately, there is no guarantee that substance abuse treatment will stop violence.\(^2\) If physical violence stops, other abusive and controlling behavior often replaces it.\(^2\) A perpetrator must confront attitudes that support violence.

*Does being a victim of violence cause substance abuse?*

Not every abused woman uses alcohol or drugs. So there is not a direct cause-and-effect relationship. But trauma can increase a woman’s risk for substance abuse.\(^1\) Some women may use alcohol or drugs as an anesthetic, to relieve the pain caused by violence.\(^1\) If the pain continues, and the “self-medicating” continues, conditions are perfect for addiction to develop.

*If a woman abuses alcohol or drugs, does this mean she asks for trouble?*

No woman deserves to be abused in any way, no matter what else is going on. If she is in a relationship, does this mean her partner must overlook substance abuse? No. Her partner has a right to ask that she get counseling or other help. Her partner has a right to end the relationship. But drinking or drug use never justifies violence.

*Why is substance abuse risky in a violent situation?*

While substance abuse does not cause violence, it can make a violent situation more dangerous. If the perpetrator is intoxicated, there is a greater risk the victim will be injured or killed.\(^2\) If the victim is intoxicated, she may find it harder to get safe.\(^2\)
Women coping with violence and their own substance abuse may find themselves caught up on a merry-go-round. Substance abuse makes it harder to escape a violent situation, or to heal from past abuse. Continuing violence or unresolved feelings about abuse make it harder to stay away from alcohol or drugs.

**How does substance abuse interfere with safety?**

Substance abuse impairs judgment. This makes safety planning more difficult. The victim may avoid calling police for fear of getting arrested or being reported to a child welfare agency. She may be denied access to shelters or other services if she is intoxicated.

**How does substance abuse interfere with healing from violence?**

If a woman is abusing alcohol or drugs, it is hard to heal the pain caused by violence. Counseling or therapy sessions can bring out strong emotions. Alcohol and drugs cut off these emotions, and the feelings get pushed back down inside. So the work cannot go forward. The healing doesn't happen. The pain continues.

**How does violence interfere with recovery from addiction?**

A woman may use alcohol or drugs to "stuff" her feelings about the abuse. When she stops drinking alcohol or using drugs, buried emotions may come to the surface. These feelings of pain, fear or shame can lead to relapse if not addressed.

In an abusive relationship, a woman’s recovery may threaten her partner’s sense of control. To regain control, her partner may try to undermine her recovery. Her partner may pressure her to use alcohol or drugs. Her partner may discourage her from seeing her counselor, completing treatment, or attending meetings. Her partner may escalate the violence.

**How can a woman get off this merry-go-round?**

Many women have found they will need to address both the substance abuse and the violence. A domestic violence agency can help a woman who is in an abusive relationship. A rape crisis center can help if she has been sexually assaulted or sexually abused. Substance abuse treatment can help if she has problems with alcohol or other drugs. No matter where she goes for help first, her counselor or advocate can make referrals. This way, she can get all the services she needs.

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4 Simmons, Katherine P., Terry Sack and Geri Miller. Sexual Abuse and Chemical Dependency: Implications for Women in Recovery. *Women and Therapy* 19 (2), 22
To Label or Not to Label?

Labels: Are they oppressive? A necessary evil? Or empowering?

Few things are more controversial than the use of labels. Some helping professionals are opposed to the use of any kind of label for any reason, while others consider labels a necessary evil. 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.

**Here are some of the drawbacks of labels:**

- 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 (2006) refers to a DSM-IV 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.
• 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).

**However, some believe that labels can be helpful under certain circumstances:**

• A label can help an individual get needed services or accommodations. For example, insurance companies usually require a DSM 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 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 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.” Believe me, 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 “multi-abuse trauma” can help the individual see certain behavior as a coping mechanism rather than as an indication of defective character. Judith Herman, author of *Trauma and Recovery* points out that people who have experienced trauma are often relieved simply to learn the true name of their condition. This 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. Does the person affected find it helpful or not?

• Distinguish between labeling a person and naming a problem. Naming a problem, issue, or experience can be empowering and liberating. Labeling a person often oppresses and disempowers.

• Evans and Sullivan (1995) suggest that 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.

Sources


Herman, J.L. (1997). Trauma and recovery: The aftermath of violence from domestic abuse to political terror. New York: Basic Books.
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

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.
orientation, and need to be accommodated and respected.

Communication should be age and developmentally appropriate as well as culturally relevant. For example, people with developmental issues such as Fetal Alcohol Spectrum Disorders (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 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, transphobia, and any other form of oppression that contributes to interpersonal violence.

References


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


## Manifestations of Violence

Abuse can occur in different forms. It can be physical, emotional, sexual, spiritual, social and/or economic. The lists below describe some of the tactics of abuse batterers use as they attempt to gain or maintain power and control over their intimate partners. Abuse does not always progress in regular steps as shown here. Sometimes the abuse may advance from pushing or hitting directly to more severe physical violence such as use of weapons. Although each relationship is unique, any type of abuse must be considered a serious cause for concern. Despite different circumstances, it is important to remember abuse can escalate (especially if intervention fails to occur). A coordinated community response holding batterers accountable for these abusive behaviors is essential as is a response acknowledging and respecting the rights of DV victims. **EXERCISE:** It is helpful for people to be aware of the tactics of domestic violence. Circle the type(s) of abuse you are now experiencing, (or have experienced in the past). Notice if the violence is increasing in intensity, severity or frequency. Talk to an advocate to develop or review your current safety plan or explore your options. Remember, domestic violence or sexual abuse directed at you is never your fault *(even if you were drinking or using drugs)*.

### Emotional Abuse

<table>
<thead>
<tr>
<th>insulting jokes</th>
<th>ignore feelings</th>
<th>jealousy</th>
<th>isolation</th>
<th>humiliation</th>
<th>harming pets</th>
<th>calls you ‘crazy’, ‘drunk’, or ‘junkie’</th>
</tr>
</thead>
<tbody>
<tr>
<td>silent treatment</td>
<td>insults</td>
<td>blaming/ accusations</td>
<td>monitoring activities</td>
<td>threats</td>
<td>degradation</td>
<td>homicide/suicide</td>
</tr>
</tbody>
</table>

### Physical Abuse

<table>
<thead>
<tr>
<th>scratch</th>
<th>slap</th>
<th>push</th>
<th>hit</th>
<th>target hit</th>
<th>kick</th>
<th>choke-hold beat or strangle</th>
<th>weapon use</th>
<th>murder</th>
</tr>
</thead>
<tbody>
<tr>
<td>deny physical needs</td>
<td>bite</td>
<td>force drug use</td>
<td>punch</td>
<td>throw objects</td>
<td>burn</td>
<td>sleep deprivation</td>
<td>poison</td>
<td>disablement/disfigurement</td>
</tr>
</tbody>
</table>

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### Manifestations of Violence, continued

#### Sexual Abuse

<table>
<thead>
<tr>
<th>embarrassing comments</th>
<th>ignore sexual needs</th>
<th>forced to look at pornography</th>
<th>sex as duty</th>
<th>control contraceptives</th>
<th>forced prostitution for drugs</th>
<th>forced sex soon after pregnancy</th>
<th>death</th>
</tr>
</thead>
<tbody>
<tr>
<td>sexual jokes</td>
<td>unwanted touching</td>
<td>treat like sex object, 13th step</td>
<td>withhold sex as punishment</td>
<td>demand monogamy when abuser is promiscuous</td>
<td>sex after violence</td>
<td>rape</td>
<td></td>
</tr>
</tbody>
</table>

#### Social / Environmental Abuse

<table>
<thead>
<tr>
<th>uses gender myths/roles</th>
<th>destroys property</th>
<th>controls major decisions</th>
<th>controls money or finances</th>
<th>threatens to victim’s family/friends</th>
<th>complete isolation</th>
<th>convinces victims they are hysterical/paranoid/suicidal</th>
</tr>
</thead>
<tbody>
<tr>
<td>degrades culture, religion gender, profession, recovery from substance abuse, etc.</td>
<td>demonstration of strength</td>
<td>denies access to work</td>
<td>eliminates support system including access to health care or substance abuse treatment</td>
<td>child abuse/suicide</td>
<td>incest</td>
<td></td>
</tr>
</tbody>
</table>
MODEL MEDICATION POLICY FOR DV SHELTERS

Introduction

As state domestic violence coalitions and local domestic violence programs across the country work to create more accessible and trauma-informed shelter programs, staff and advocates have sought guidance on designing medication policies that better serve survivors who are experiencing mental health symptoms or living with mental health disabilities.

This Model Medication Policy for Domestic Violence Shelters, developed in response to these requests, is intended to provide coalitions and programs with guidance on designing medication policies that reflect survivor-centered values and to help to create more accessible and trauma-informed shelter environments. It also responds to requests from domestic violence programs for guidance on drafting policies that comply with their ethical and legal obligations under the Americans with Disabilities Act (ADA), the Fair Housing Act (FHA), and Section 504 of the Rehabilitation Act. These three federal statutes have implications for how domestic violence shelters screen and admit survivors and how they store and handle medications.

While this Model Policy is intended to guide domestic violence coalitions and programs as they work to draft medication policies and train staff in ways that support survivors and their children who are experiencing mental health symptoms or living with mental health disabilities, it is not a substitute for legal counsel. Domestic violence programs should consult with an attorney to ensure that their policies comply with all relevant local, state, and federal laws.

For more information or to provide feedback on this Model Policy, please contact the National Center on Domestic Violence, Trauma & Mental Health at 312-726-7020 (P), 312-726-4110 (TTY), or info@nationalcenterdvtraumamh.org.

Written by Mary Malefyt Seighman, JD, Kelly Miller, JD, and Rachel White-Domain, JD, on behalf of the National Center on Domestic Violence, Trauma & Mental Health.

1 The Americans With Disabilities Act (42 U.S.C. §§ 12101 et seq.).
Shelter Policy on Medications

I. Purpose

________________________ (“the shelter”) is committed to providing a safe, accessible, and trauma-informed environment for survivors of domestic violence and their children. In addition, the shelter acknowledges its ethical and legal obligations to serve survivors of domestic violence and their children without regard to disability status. To these ends, the shelter has adopted this medication policy. All staff and volunteers will receive training on and copies of this policy. Staff and volunteers are responsible for complying with the policy and for seeking guidance from a supervisor if they have any questions or concerns about the policy.

II. Definitions

For purposes of this policy, the following definitions will apply:

1) Medication means any drug that is legally in the possession of the survivor, her children, or a person seeking admittance to the shelter or her children; this definition includes prescription medications and medications available for legal purchase without a prescription.

2) Dispensing medication means distributing or providing medication to a person staying at the shelter by opening a locking closet or container and handing the medication container or individual dosage to another person.

3) Mental health disability, as defined by the ADA, means a mental health-related (1) “impairment that substantially limits one or more major life activities,” (2) “a record of such an impairment,” or (3) “being regarded as having such an impairment.”

The World Health Organization International Classification of Functioning, Disability and Health (ICF) defines disability as “the outcome or result of a complex relationship between an individual’s health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives.” Thus, disability is not a static state of impairment but “falls on a continuum from enablement to disablement.” Trauma and mental health conditions can precede psychiatric disability but do not always do so. Psychiatric disability occurs when the effects of trauma and/or mental health conditions significantly interfere with the performance of major life activities. Psychiatric disability may come and go, remit, or be more persistent. Safety and support can reduce psychiatric disability.

________________________

4 The Americans With Disabilities Act (42 U.S.C. §§ 12101 et seq.).
A person who is in recovery from an addiction to illegal drugs or alcohol is considered disabled and protected from discrimination under the ADA. However, disability status is not conferred by the use of illegal drugs. Current users of illegal drugs and persons convicted for illegal manufacture or distribution of a controlled substance are not considered disabled by virtue of that activity or status.5

III. Policy Provisions

A. Advocacy Related to Mental Health and Medications

The shelter seeks to create a welcoming and inclusive environment in which all survivors are empowered to identify and access the support and resources that they need. The shelter does not discriminate against or “screen out” survivors based on their or their children’s disability status or use of medications. However, the shelter recognizes that offering advocacy related to mental health, disability, and use of medication can be a critical component to comprehensive safety planning and to ensuring that all of the survivor’s needs are addressed.

1) Staff and volunteers will not ask questions about survivors’ or their children’s mental health status, disability, or use of medications as part of the screening process.

2) Staff and volunteers will provide every survivor who is residing at the shelter with a copy of this medication policy and/or an explanation of the policy.

3) Staff and volunteers will offer every survivor information and advocacy related to mental health, disability, and medications. Here are some examples of how staff and volunteers can start this conversation:

   “Experiencing abuse can affect how we feel and respond to other people and the world around us.”

5 Neither the ADA nor the FHA prohibits programs from serving survivors who are currently using illegal drugs. The survivor would simply not be protected under the ADA and FHA on that basis. While not considered a disability under the ADA or FHA, use of alcohol or other drugs can be disabling and is often a form of self-medication for the traumatic effects of abuse or mental health conditions. Survivors may also be coerced into using alcohol or other drugs by an abusive partner. Therefore, while not the focus of this policy, employing strategies to support survivors with regard to alcohol and other drugs is a critical part of ensuring that DV services are accessible and survivor centered.
“Many people who have been abused experience strong feelings such as anger, sadness, or hopelessness, or they may have difficulty sleeping, eating, or getting things done in a day.”
“I hope that this can feel like a safe space to talk about how you’re feeling.”
“At this shelter, we don’t judge people or refuse services to people based on their mental health status.”
“If you want to, I hope that this can feel like a safe space to talk about any mental health needs you might have.”
“When people come to shelter, they sometimes have to leave important medications behind. If you need help getting medications that you left behind, you can let us know and we will try to help.”

4) Staff and volunteers will **not make assumptions** about the mental health status, disability, or use of medications by survivors or their children; instead, staff and volunteers will offer the same information and advocacy related to mental health, disability, and medications to **every** survivor.

B. Storage and Dispensation of Medications

The shelter seeks to afford shelter residents with the greatest possible privacy and autonomy, while also providing a safe shelter environment.

1) Staff and volunteers will **not** store or dispense medication or monitor how survivors access medications.

2) The shelter will provide **every** survivor with an individual locking box, locker, or locking cabinet (“locked space”) for storage of medications and valuables.

3) The shelter will **not** limit or monitor the survivor’s access to her locked space, such as by holding the key in the shelter office.

4) If a survivor indicates that she needs access to refrigerated storage space, the shelter will provide refrigerated storage space in the manner that provides the greatest possible privacy and autonomy.

C. Safety Agreement

During a survivor’s stay at shelter, staff and volunteers will ask her to make sure that any medications she has are safety secured.

1) The shelter will ask every survivor to sign an agreement that she will store any medications in her individual locking box, locker, or locking cabinet.
provided, or if it is one requiring refrigeration, as otherwise provided. The agreement will provide that survivors who have medications that must be taken in the event of a medical emergency may carry them on their person (e.g., in a fanny pack).

2) In the event that the survivor has concerns about signing the agreement, staff or volunteers will ask the survivor if an accommodation or change to the policy would allow her to comply. If the staff or volunteer and the survivor cannot find a reasonable accommodation to the policy and non-compliance poses a direct threat to the safety of the survivor or to others, the survivor can be asked to leave shelter.

D. Accommodations

The shelter recognizes that survivors come to the shelter with many diverse needs. As advocates, we are committed to meeting the individual needs of each survivor. Whenever possible, we will make accommodations to ensure that our shelter is accessible to all survivors.

1) Survivors will not be required to take medication as a condition of shelter or receipt of services.

2) If a survivor has difficulty following any rule or policy of the shelter because of her mental health condition or use of medication, the shelter staff will work with the survivor to find a reasonable accommodation.6

3) If a survivor engages in behavior that is related to her mental health condition or use of medication and that poses a direct threat to herself or other people, the shelter will (1) take steps to ensure the immediate safety of all individuals and then (2) work with the survivor to find a reasonable accommodation that is aimed at eliminating future threats.

4) A survivor will not be asked to leave shelter unless (1) her behavior or inability to follow a rule or policy poses a direct threat to herself or other people, (2) there is no reasonable accommodation that would eliminate the

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6 Examples: (1) A client whose medication causes her to experience nausea will not be required to participate in meal preparation. (2) A client whose medication makes it difficult for her to sit through group meetings may be excused when she feels she must leave. (3) A client whose medication makes her very sleepy and/or who needs extra sleep may work out an alternative schedule with staff for her attendance at job training or other required activities.
direct threat, and (3) all possible and appropriate referrals are made to ensure the safety and well-being of the survivor and others.

E. Providing Access to Information About Medications

1) Staff and volunteers will not provide advice about medications unless they are authorized by law and the shelter to do so.

2) Staff and volunteers may provide Internet access for clients to find out information about medications.

F. Nurse and Physician Visits

The shelter recognizes that abuse can affect a person’s mental health and that mental health services can sometimes be a critical component of the services that survivors and their children need to heal from trauma. The shelter also recognizes the right of each person to control her own mental health care.

1) The shelter will make every effort to provide access to mental health services including, when possible, arranging for a mental health professional to visit the shelter on a regular basis to answer questions about medications, to provide medication evaluations, and/or to prescribe medication.

2) Survivors and their children will not be required to meet with mental health professionals, participate in mental health treatment, or take medication as a condition of shelter or receipt of services.

G. Policy Violation

1) If a staff member or volunteer becomes aware of a violation of this policy by another staff or volunteer, she is required to report the violation to her direct supervisor or to the appropriate person as indicated in the employee manual.

2) If a supervisor becomes aware of a violation of this policy, the supervisor is responsible for addressing the issue with the staff member or volunteer observed violating the policy or that person’s supervisor.

3) When addressing a violation of the policy with a staff member or volunteer, the supervisor will employ reflective supervisory practices, including discussion about the individual’s understanding of the policy and rationale for violating it, steps to remediate, and plan for follow-up supervision.
4) Violation of this policy by a staff member or volunteer can result in verbal warning, written reprimand, temporary suspension, or termination, depending on the nature of the violation.

This policy was adopted on ______________________(date).

______________________________________________
Authorized Signature
TALKING ABOUT MENTAL HEALTH AND MEDICATIONS WITH SURVIVORS IN SHELTER
TALKING POINTS FOR DV ADVOCATES

As advocates, we are committed to making every survivor and child feel welcomed at the shelter. We know that everyone comes to shelter with different needs and we are committing to providing everyone with the support and advocacy that she needs to access safety and heal from trauma.

The shelter does not discriminate against or “screen out” survivors based on their or their children’s disability status or use of medications. At the same time, offering advocacy related to mental health, disability, and use of medication can be a critical component to comprehensive safety planning and to ensuring that all of the survivor’s needs are addressed.

Don’t ask. Offer.

When speaking with a survivor, you should not ask her to reveal information about her or her children’s mental health status, disability, or medications. Instead, you should simply offer the same advocacy related to these issues to every survivor by using conversation starters such as the following:

“Experiencing abuse can affect how we feel and respond to other people and the world around us.”

“Many people who have been abused experience strong feelings such as anger, sadness, or hopelessness, or they may have difficulty sleeping, eating, or getting things done.”

“I hope that this can feel like a safe space for you to talk about how you’re feeling.”

“At this shelter, we don’t judge people or refuse services to people based on their mental health status.”

“If you want to, I hope that this can feel like a safe space to talk about any mental health needs you might have.”

“When people come to shelter, they sometimes have to leave important medications behind. If you need help getting medications that you left behind, you can let us know and we will try to help.”
MEDICATION SAFETY AGREEMENT

Welcome to the shelter. We are committed to providing you with the greatest possible privacy and autonomy during your shelter stay, while also providing a safe shelter environment for everyone.

We recognize that you or your children may have medications with you. If so, you must keep them secured during your stay. We will provide you with an individual locking box, locker, or locking cabinet (“locked space”) for storage of these medications. You are responsible for making sure that any medications belonging to you or your children are safety secured in this locking space at all times. You may also use the locked space to store other belongings.

If you have medications that must be taken in the event of a medical emergency, you may carry them on your person (e.g., in a fanny pack). You are responsible for keeping these medications out of the reach of children at all times.

If you have any questions or concerns about this policy, or if you need a change or accommodation to this policy, please alert a staff member before signing. We would be happy to work with you to find a reasonable accommodation.

If you agree to this policy, please sign below.

____________________________________
Name

____________________________________
Signature

____________________________________
Date
“Stages of Addiction, Stages of Untreated Trauma”

- Feels Uncomfortable
- Use to feel good
- Use not to feel
- CD Harmful to health
- Rationalization
- Lies about use
- Lack of self respect
- Withdrawals
- Isolation
- Feels Useless
- Full of Shame
- High Risk Behavior
- Using Relationships
- Overdoses

- Feels Unsafe
- Emotional Numbing begins
- Restricted Emotions
- Self Harm Behaviors
- Fantasy thinking
- Learns to Lie
- Blames Self
- Physical Reactivity
- Disconnects
- Apathy
- Self Degradation
- Sexual Dysfunction
- Unhealthy relationships
- Suicide Attempts

POWERLESS
HOPELESS
ALONE
DEATH

Continued Recovery
- Self Worth
- Trust in self
- Freedom of choice
- Acceptance
- 3D Coping Skills
- Connection with others

Integrated 3D Treatment Recognition
- Feeling overwhelmed
- One dimensional TX
- Emotional Immaturity

Feeling emerging
- Emotional numbing dissipates
- Begins counseling
- In a safe environment
- Seeks Help
- Hospitalization
- Substance Free
- Willingness to change
- Detoxification

© 2005, 2011 by Tia M. Holley CDCII, NCACI From Real Tools: Responding to Multi-Abuse Trauma Alaska Network on Domestic Violence and Sexual Assault
I created this "dip chart" or "Likert scale" to show the parallel paths that untreated trauma and untreated addictions follow. In early recovery feelings begin to emerge and emotional numbing dissipates. If the multidimensional issues are not addressed concurrently there is a high risk of relapse because the emerging overwhelming emotions push the person back to the bottom of the vicious cycle.

On the upside is how healing on multiple dimensions; body, mind, spirit, and emotional levels can help survivors get beyond the vicious cycle of pain.

The three dimensional treatment originally addressed with this scale was the combined strengths of providing integrated Traditional healing, mental health services and addiction treatment. The three dimensional coping skills are mental, physical and spiritual.

– Tia M. Holley
Merry-Go-Round of Addiction

Use

Craving

Sick/Sorry

Rationalizing
Minimizing
Denial

Adapted from Real Tools: Responding to Multi-Abuse Trauma, ANDVSA, 2011
Merry-Go-Round of Violence

Acute Abusive Incident

Atmosphere of Abuse

Rationalizing
Minimizing
Denial

Aftermath of Violence
**INSTRUCTIONS FOR MERRY-GO-ROUND EXERCISE**

Group participants discuss both Merry-Go-Rounds and compare/contrast similarities and differences. People in treatment use addiction diagram first; those in domestic violence programs use abuse diagram first.

*Merry-Go-Round of Addiction:* Provide Merry-Go-Round diagram to group participants and draw copy on white board or flip chart. Discuss Craving, Use, and Sick and Sorry with group participants. Brainstorm group responses to the questions below and write answers down on the board. Discuss the role rationalizing, minimizing, and denial play to keep the merry-go-round in motion. (When discussing "Use," it’s okay to be brief, look for initial feeling and move on to "Sick and Sorry" to avoid euphoric recall.)

<table>
<thead>
<tr>
<th>When I am craving:</th>
<th>When I am using:</th>
<th>When I am sick and sorry:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do I feel physically?</td>
<td>How do I feel physically?</td>
<td>How do I feel physically?</td>
</tr>
<tr>
<td>How do I feel emotionally?</td>
<td></td>
<td>How do I feel emotionally?</td>
</tr>
<tr>
<td>What are my thoughts?</td>
<td></td>
<td>What are my thoughts?</td>
</tr>
<tr>
<td>What do I say?</td>
<td></td>
<td>What do I say?</td>
</tr>
<tr>
<td>Where am I spiritually?</td>
<td></td>
<td>Where am I spiritually?</td>
</tr>
<tr>
<td>Where am I economically?</td>
<td></td>
<td>Where am I economically?</td>
</tr>
<tr>
<td>Where am I socially?</td>
<td></td>
<td>Where am I socially?</td>
</tr>
<tr>
<td>Where am I sexually?</td>
<td></td>
<td>Where am I sexually?</td>
</tr>
</tbody>
</table>
**Merry-Go-Round of Abuse:** Provide diagram to group participants and draw copy on board. Discuss Atmosphere of Abuse, Acute Episode and Aftermath with group. Brainstorm group responses to the questions below and record answers on the board. Discuss the role rationalizing, minimizing, and denial play to keep the merry-go-round in motion. (When discussing “acute episode,” it’s okay to be brief. Graphic details may re-traumatize.)

<table>
<thead>
<tr>
<th>When I live in an atmosphere of abuse:</th>
<th>When I experience an acute episode of abuse: Note: Abuse is pervasive. Acute abusive incident may be physical, emotional or verbal, sexual, economic or any other form of harm, coercion or threat to gain or maintain power and control.</th>
<th>When I live in the aftermath of violence:</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do I feel physically?</td>
<td>How do I feel physically?</td>
<td>How do I feel physically?</td>
</tr>
<tr>
<td>How do I feel emotionally?</td>
<td></td>
<td>How do I feel emotionally?</td>
</tr>
<tr>
<td>What are my thoughts?</td>
<td></td>
<td>What are my thoughts?</td>
</tr>
<tr>
<td>What do I say?</td>
<td></td>
<td>What do I say?</td>
</tr>
<tr>
<td>Where am I spiritually?</td>
<td></td>
<td>Where am I spiritually?</td>
</tr>
<tr>
<td>Where am I economically?</td>
<td></td>
<td>Where am I economically?</td>
</tr>
<tr>
<td>Where am I socially?</td>
<td></td>
<td>Where am I socially?</td>
</tr>
<tr>
<td>Where am I sexually?</td>
<td></td>
<td>Where am I sexually?</td>
</tr>
</tbody>
</table>
Ending Isolation: Reducing Anxiety through Connection

Women seeking safety, sobriety, wellness, and justice face many barriers. Simple tasks can be frightening or overwhelming at times. Going to court, interacting with Children’s Services or just setting foot outside can bring on fear and anxiety. This uneasiness is compounded when a person feels all alone. Women attending support groups together can serve as a safety net of caring individuals. Women facing similar struggles can reduce isolation, anxiety and fear through their connection to each other.

The women at New Beginnings Wednesday night Support Group came up with the following plan themselves. A member of the group was terrified to go to court alone. She was afraid she would have a panic attack, take a drink, or crumple when she saw her abuser. None of these options felt good and she said in anguish, “If I just could take all of you with me, I wouldn’t feel so all alone.” Another group member said, “Maybe we could help you. We can’t physically go but we could all write down a message for you and you could carry it into court with you. Then we would be with you. You would not be alone.” Another group member said, “We can write down our numbers and you can call us before you go in, or if you get scared or after you leave.” We can make a safety plan together,” said yet another. “You can call us if you are thinking of taking a drink, feel like fainting, or if your partner says or does something hurtful or scary.”

That evening the women passed around a piece of paper. Everyone in the group wrote a note of support and provided phone numbers. A simple plan was formed. The next day our group member went to court but she was not alone. She had the power of the group on the paper in her pocket. She took the paper out and read, “We believe you. You can do it. We care.” She used the phone numbers. She got through the day and she knew people believed her and cared for her. She said, “When I came in here I felt lower than the rug and so alone. Now I know I’m part of something bigger than myself. There’s a whole movement out there made up of people just like me, and we are there for each other.”

Today when any group member feels afraid, and doesn’t think she can handle a court date or other event alone, group members remind her, “You are not alone.” They ask for paper and pen. Sometimes they write down their words of support; other times they designate a group member to write down words of wisdom and support. It is very healing and empowering to feel safe enough to tell your story, to be believed, and to feel connected. This simple tool is most useful and empowering because it is rooted in the experience, strength and hope of women like you. Do you need help from the group today? It is okay to ask for support if you need it now. Today you are not alone.

Note: Some members may choose NOT to provide a phone number if doing so is uncomfortable or poses a safety risk.
Safety at Community Support Group Meetings

Community support groups can serve as a valuable supplement to counseling or advocacy. Much of the power in these groups comes from the personal stories. People share their experience, strength and hope with each other. When one person breaks the silence about “unspeakable” experiences, especially those that carry a lot of stigma, others feel safer breaking their silence. You also hear success stories. You hear what others are doing to cope with problems similar to yours.

Some initial discomfort is normal if you’re new to support groups. It is natural to feel nervous in a roomful of strangers. You may have spent years avoiding the issues the group is discussing. If your experience includes violence or abuse, you also may have safety concerns. Here are some tips to help you feel comfortable — and stay safe:

- **Protect your safety.** Most people in support groups respect confidentiality (anonymity). However, if you are leaving an abuser, don’t share information that could put your safety at risk. Do carry your cell phone with you to 12-Step meetings or other support group meetings if you have one. Tell your sponsor or someone else at the meeting what is going on.

- **Find a home group.** For people who attend 12-Step groups, this is a group you attend regularly. You get to know other “regulars” and feel more comfortable talking at meetings. Some 12-Step veterans have two or three home groups. If you need to avoid being predictable to an abuser, have a back-up home group. Alternate between one meeting and the other one.

- **Shop around.** You will probably notice that each support group has a distinct personality, depending on who attends. For example, larger communities may have a number of different Alcoholics Anonymous groups holding meetings in a given week. Sample several. Some people feel most comfortable in small, intimate groups. Others may feel more comfortable at meetings with large numbers of people in attendance, because they can sit back and listen and feel less pressure to speak or contribute right away.

- **Recognize the group’s limitations.** Support group meetings are not meant to be a substitute for professional help. Use sessions with a counselor or advocate for issues that are beyond the group’s scope.

- **Respect your own boundaries.** Some people may try to sexually exploit others in the group. 12-Step groups call this practice “13th Stepping,” and most consider such behavior unethical. You don’t have to tolerate it! Also, don’t feel compelled to talk about painful abuse issues in groups if this makes you uncomfortable.

- **Try “specialty” groups.** In many communities, Alcoholics Anonymous has “Beginner’s Groups” designed for people who are new to recovery. Some women who are survivors of domestic violence or sexual abuse may have difficulty setting healthy boundaries, especially with men, and report that women-only meetings feel safer than meetings where both men and women are present. One can also find 12-Step groups especially for lesbian, gay, bisexual, and transgender identified people.

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From Real Tools Responding to Multi-Abuse Trauma
Alaska Network on Domestic Violence And Sexual Assault
Using 12-Step Groups

People recovering from addictions often participate in 12-Step groups such as Alcoholics Anonymous or Narcotics Anonymous. Many find these groups a helpful source of support. If you have experienced violence or abuse, here are some ideas to consider while “working the program.” As they say in 12-Step groups, take what you need and leave the rest.

**Step One: We admitted that we were powerless over alcohol (or our addiction) — that our lives had become unmanageable.**

When 12-Step groups discuss powerlessness, it may be helpful to explore how power is defined. Some people view power as the ability to control other people, places, and things. “The program” asks you to let go of attempts to have this kind of power.

However, power can also be defined as the ability to make choices and act on them. For example, you cannot control the impact of chemicals on your body. But you can choose to seek treatment for an addiction. If you are in an abusive relationship, you cannot control your partner’s behavior. But you can choose to seek help getting safe.

This step encourages you to break through denial and acknowledge that you are out of control with alcohol or another addiction. Before you can do something about a problem, you must acknowledge that the problem exists.

**Step Two: Came to believe that a power greater than ourselves could restore us to sanity.**

Some women feel more comfortable with feminine or gender-neutral images of God or “higher power.” This may be especially true for women who have been abused by a male parent or partner. Remember that 12-Step groups encourage you to interpret “higher power” in whatever way feels right for you. A.A. literature says, “When we speak of God, we mean your own conception of God.”¹ In fact, “You can, if you wish, make A.A. itself your ‘higher power.’ Here’s a very large group of people who have solved their alcohol problem.”²

This step encourages you to feel hope. There is a way out of your problems. Help is available. Recovery and healing are possible.

**Step Three: Made a decision to turn our will and our lives over to the care of God as we understood Him.**

For some women, turning over our will to someone else may sound like a demand from an abuser. It may be helpful to remember that there is a difference between turning one’s will over to a deity (if that is what your religious or spiritual tradition teaches), and being asked to turn your will over to another human being.

It may also be helpful to think of “turning it over” as “letting go,” and willingness as being open to new ideas. Giving up an addiction (or a relationship) can feel pretty scary. You are letting go of something familiar without knowing what will replace it. The good news is you don’t have to do this alone.

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This step encourages you to break your isolation by seeking help and accepting the support that is offered.

**Step Four: Made a searching and fearless moral inventory of ourselves.**

Keep in mind that Step Four is not an “immoral inventory.” A.A. literature points out that “assets can be noted with liabilities.” Listing your strengths can be especially helpful if your self-esteem has been battered by abuse.

A.A. literature suggests that you “consider carefully all personal relationships which bring continuous or recurring trouble. Appraising each situation fairly, can I see where I have been at fault? ... And if the actions of others are part of the cause, what can I do about that?” When looking at relationships, remember that you are not responsible for violence or abuse committed against you. However, exploring the impact abuse has had on your life can strengthen your resolve to break free of the abuse and heal from it.

This step encourages you to take a realistic look at your life. This allows you to discover your strengths and limitations, and identify your needs.

**Step Five: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.**

When you choose someone to hear your Fifth Step, A.A. literature cautions you to “take much care.” This care is especially important if you are a survivor of domestic violence, sexual assault, or sexual abuse. Survivors may want to share this part of their experience with a qualified therapist or advocate. This person should understand that responsibility for violence belongs with the perpetrator.

This step encourages you to share your past with someone you trust. This can help you let go of the shame that comes with thinking you must keep parts of your life secret.

**Step Six: Were entirely ready to have God remove these defects of character.**

Nobody is perfect, so self-improvement is a worthy goal for everyone. But A.A. literature cautions you to “avoid extreme judgments” and “not exaggerate” your defects. This precaution is especially important for abused women. An abuser may have whittled away at your self-esteem by encouraging you to feel defective. A person who wants to control you is not the best judge of your character!

A.A. literature also reminds you to distinguish between societal expectations and your own values. For example, when the subject is sex, “we find human opinions running to extremes — absurd extremes, perhaps.” This can certainly be said about the messages our society directs toward women. Women also get mixed messages about everything from their roles to how they should look or act. Step Six can be a good place to examine what your own values are.

This step encourages you to prepare for change in your usual patterns of behavior. What behaviors do you want to let go of? What patterns do you want to stop repeating?
Step Seven: Humbly asked Him to remove our shortcomings.

A.A. literature says humility is “a word often misunderstood. ... It amounts to a clear recognition of what and who we really are, followed by a sincere attempt to become what we could be.”8 We should “be sensible, tactful, considerate and humble without being servile or scraping.”9 And, “we stand on our feet; we don’t crawl before anyone.”9 Humility does not mean seeing yourself as less important than others.

This step encourages you to begin letting go of the unhealthy patterns you identified in Step Six. If some of these patterns stem from your experience of violence or abuse, you may want to seek professional help from a person trained to work with abuse survivors.

Step Eight: Made a list of all persons we had harmed and became willing to make amends to them all.

People in recovery need to acknowledge how their drinking or drug use affected others. But recovery groups remind you to make amends to yourself as well. One such amend might be to stop blaming yourself for domestic violence, sexual assault, or other abuse. You are only responsible for your own behavior, not someone else’s.

This step encourages you to identify what needs changing in your relationships with others. "Making amends" does not mean you must reconcile with an abuser. “Amend” simply means “to change or modify for the better.”10 With an abusive relationship, this may well mean ending it. According to the A.A. literature, “If there be divorce or separation, there should be no undue haste for the couple to get together. ... Sometimes it is to the best interests of all concerned that a couple remain apart.”11

Step Nine: Made direct amends to such people wherever possible, except when to do so would injure them or others.

If you have left an abusive relationship, it may be best to avoid your partner. This is true even if you believe you did something "wrong." A.A. literature does not say you must contact everyone on your amends list. In some cases, “by the very nature of the situation, we shall never be able to make direct personal contact at all.”12 If "making amends" to an abuser would put you or your children in danger, stay away!

Children often blame themselves for their parents’ problems. So this can be a good time to talk with your children about incidents they have witnessed. Explain that they are not responsible for your alcohol or drug use. Nor are they responsible for an abuser’s behavior toward you or them.

This step encourages you to settle with the past. “When this is done, we are really able to leave it behind us.”13

Step Ten: Continued to take personal inventory and when we were wrong promptly admitted it.

When doing an inventory, remember to focus on strengths as well as weaknesses.
A.A. literature points out that “inventory-taking is not always done in red ink. It’s a poor
day indeed when we haven’t done something right.”  

This step encourages you to maintain the progress you have made in previous
steps. And give yourself credit for things well done!

**Step Eleven: Sought through prayer and meditation to improve our
conscious contact with God as we understood Him, praying only for
knowledge of His will for us and the power to carry that out.**

This step encourages you to develop emotional balance. For you, this could mean
prayer and meditation. It could mean keeping a journal or taking daily walks. It
could mean calling a friend to help you sort out your feelings. Do whatever helps
you feel centered and at peace with yourself.

**Step Twelve: Having had a spiritual awakening as a result of these steps,
we tried to carry this message to alcoholics, and to practice these
principles in all our affairs.**

A.A. literature says “helping others is the foundation stone of your recovery.” You
can do this by sharing your experience, strength and hope with other people like
you. When you take back your life from addiction (or abuse), you carry a powerful
message!

Many recovering alcoholics and addicts believe carrying their message to others
helps them stay clean and sober. Many survivors of violence find that working for
social change aids their own healing process. People may call their efforts working
for change, service to others or carrying the message. This step encourages you to
discover what you have to offer and to pass it on!

**Note:** The views expressed in this handout are the views of the author only. The author makes no
claim to speak for Alcoholics Anonymous, Narcotics Anonymous or any other 12 Step group.

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3. *Twelve Steps and Twelve Traditions*, p. 52
4. *Twelve Steps and Twelve Traditions*, p. 6
5. *Twelve Steps and Twelve Traditions*, p. 61
6. *Twelve Steps and Twelve Traditions*, p. 82
7. *Alcoholics Anonymous*, p. 68
8. *Twelve Steps and Twelve Traditions*, p. 58
9. *Alcoholics Anonymous*, p. 83
12. *Twelve Steps and Twelve Traditions*, p. 83
13. *Twelve Steps and Twelve Traditions*, p. 89
14. *Twelve Steps and Twelve Traditions*, p. 93
15. *Alcoholics Anonymous*, p. 97
Mini Safety/Sobriety/Wellness Plan

★★ Strategize  Steps to reduce risk/use/harm
★★ Develop   Options to keep safe/sober/well
★★ Identify  Trusted allies/safe sponsors/supports
★★ Plan      Means to escape abuser/drugs/harm
★★ Discuss  Referral resources
★★ Avoid    Danger/persons, places, things/isolation
★★ Tools    HALT/One day at a time/medication
Mini-Safety/Sobriety Plan

You are not alone.

Remember that safety, sobriety and wellness plans will change as your situation does. Each day can bring new challenges as well as rewards. Know your resources and develop safety and survival strategies.

Components of Mini-Safety/Sobriety/Wellness Plan:

Strategize: Secure and hide money, an extra house or car key, important documents, prescription medication information, ID, receipts, pay stubs, passports, children’s school and immunization records, immigration papers, social security cards, etc.

Develop: A code with family/friends to signal the need for help.

Identify: Safe neighbor to call, network of resources who can help.

Plan: Escape routes, places to hide and store clothing, jewelry, photos.

Discuss: Referral resources, local advocates, shelter, legal options, 911.

Avoid: Rooms where weapons or dangerous implements are present (e.g., kitchens and knives).

Tools: Recognize vulnerability cues such as HALT (be aware when you are hungry, angry, lonely or tired); deal with safety, sobriety and wellness issues “one day at a time” to avoid being overwhelmed; use meditation or other activities that help you stay centered.

12 Strategies for Safety, Sobriety and Wellness

Survivors, attempting to stay safe, sober, and well may develop a plan that may include but is not limited to:

1.) Identifying who to call for help (e.g. advocate, sponsor, counselor, peer), forming support systems, knowing about safe support groups and meetings.

2.) Knowing information and getting education about domestic violence, sexual assault, addiction and mental health issues.

3.) Removing substances and paraphernalia from the home. Removing weapons from their usual spot in the home.
4.) Recognizing unsafe persons, places, and things.

5.) Understanding how to deal with legal and other problems stemming from domestic violence/sexual assault/addiction/mental health issues (e.g. health, children’s services involvement, poor nutrition).

6.) Assembling paperwork to determine eligibility for assistance or to begin seeking employment, school, housing, or other options.

7.) Knowing how domestic violence/sexual assault can be a relapse issue or interfere with the ability to cope with mental health issues.

8.) Knowing how substance use or untreated mental illness can be a safety issue.

9.) Understanding physical, emotional, cognitive, environmental, and other cues indicative of risk, and having a plan to deal with it. Recognizing the role of stress and craving, and having a plan to deal with it.

10.) Learning how to parent, engaging in relationships, developing sober friendships.

11.) Knowing when and where to run in a life-threatening situation that puts your safety, sobriety or wellness at risk.

12.) Having a code word children will recognize to let them know it’s time to call 911.
Emotional Well-Being: Sample Questions to Ensure Better Accommodation

To better accommodate an individual’s needs the following questions can be asked following intake to provide information about how staff can best respond when a survivor is having an emotional crisis:

• What are situations that are particularly difficult for you or make you feel unsafe or upset (i.e., noise, not being listened to, loneliness, being teased, contact with family, being alone, laughter, yelling, crying, being touched, time of day, particular dates/holidays, certain words, crowds, malls, bus stops, doors open/closed, smells, sounds, contact with certain people, etc.)?

• What signs do you notice when you are beginning to feel stressed and out of control (sweating, breathing hard, sleeping a lot, restlessness, crying, avoiding people, feeling hyperactive, eating more, eating less, etc.)?

• If you are anxious or angry and those feelings are getting so intense they may be impacting your safety or another person’s safety, how would you prefer that staff members assist you?

• What has been particularly helpful to you in the past when you had a difficult time with your thoughts and/or feelings (such as more time in a quiet area, physical exercise, talking to a friend or family member, taking a bath or shower, meditation, reading, leaving the room, listening to music, journaling, reading, medication, etc.)?

• What has not been particularly helpful to you in the past when you had a difficult time (such as being asked to stay in a room, not being taken seriously, noisy environment, etc.)?

• Is there a person who has been helpful to you when you were overwhelmed or distressed? Would you like to call that person if you get distressed here? Do you have that telephone number? Would you give us written consent to call this person if you are in great distress and we cannot seem to help?

• Have you noticed any triggers that you associate with being anxious or angry? If so, what are these triggers?

• Do you have coping strategies to deal with difficult memories? Group living can trigger difficult memories especially if you were ever hospitalized for mental illness or have been in treatment for substance addiction. Are there any situations that might trigger difficult memories for you here? Let us know if there are ways we can offer emotional support to you during your stay.*
• If room checks are part of the routine at the shelter: Is there anything we can do to make the room checks comfortable for you?

• If you are taking medications and have concerns about them during your stay please let us know. Sometimes an abusive partner controls medication. An abusive partner may tamper with meds, steal meds or withhold meds. If you take any medications, need them and were not able to bring them with you to shelter, let us know. We can provide you with information and referrals or advocacy to better accommodate you during your stay.

Please also advise us if you think your medication(s) is not working effectively for you or if there are any side effects from the medication(s) that we should know about to better support you during your stay. If you need or have reminders to keep your medication schedule let us know how we can help you.*

From Real Tools: Responding to Multi-Abuse Trauma
By Debi S. Edmund and Patricia J. Bland
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Reprinted by permission from Beyond Labels: Working with Abuse Survivors with Mental Illness Symptoms or Substance Abuse Issues by Dianne King Akers, M.Ed., Michelle Schwartz, M.A., and Wendie H. Abramson, LMSW (Safe Place, Austin, TX, 2007). Adapted from Carmen, E., et. al. (1996, January 25). Task force on the restraint and seclusion of persons who have been physically or sexually abused: Report and recommendations. Massachusetts Department of Mental Health. (Note: Materials with an * adapted by P. Bland, 2008).
Questionnaires such as CAGE Questions, The 4 P’s, Emotional Well-Being: Sample Questions to Ensure Better Accommodation and Where Can I Get Help? (all available for download from the Web version of Real Tools: Responding to Multi-Abuse Trauma) can help advocates and the people you serve to assess what kinds of assistance and referrals are wanted or needed. Use these questionnaires to assess needs ONLY, not to screen people in or out of your program.

When using these forms and questionnaires, keep in mind:

Information derived using these tools should not be placed in an individual’s file due to the sensitive nature of the information to be discussed and confidentiality concerns.

Do not make assumptions about the people you serve. These questions should be addressed with everyone, to determine how we can best accommodate them.

These tools should never be used as screening tools at intake. Using these tools to withhold services – that is, to screen people out – would be a violation of both the Americans with Disabilities Act and Fair Housing regulations.

Once needs have been determined, give the Where Can I Get Help? form to the individual with the appropriate referrals and contact information filled in.

If your agency offers support groups, you may wish to use the Where Can I Get Help? form as the basis for a general group discussion of resources available in the community. The group facilitator might ask, “Where would a person go who needs rental assistance?” “Where would someone go who needs a bus pass?” And so on. Then have the group fill out the form as a group activity.
WHERE CAN I GET HELP?

Please let us know what advocacy or assistance we can provide for you or your children to better accommodate your needs while you are receiving services from us.

Social Security card, birth certificate, other I.D.

Agency ___________________________ Phone: ________________

Address: __________________________________________________

Advocacy/counseling for domestic violence

Agency ___________________________ Phone: ________________

Address: __________________________________________________

Advocacy/counseling for sexual assault

Agency ___________________________ Phone: ________________

Address: __________________________________________________

Advocacy/counseling for past sexual abuse issues

Agency ___________________________ Phone: ________________

Address: __________________________________________________

Housing/rental assistance

Agency ___________________________ Phone: ________________

Address: __________________________________________________

Utilities

Agency ___________________________ Phone: ________________

Address: __________________________________________________

Adapted from Real Tools: Responding to Multi-Abuse Trauma, ANDVSA, 2011
Furnishings for home
Agency ______________________ Phone: ________________
Address: ________________________________________________

Phone/phone card
Agency ______________________ Phone: ________________
Address: ________________________________________________

Food/food stamps
Agency ______________________ Phone: ________________
Address: ________________________________________________

Grooming supplies
Agency ______________________ Phone: ________________
Address: ________________________________________________

Clothing
Agency ______________________ Phone: ________________
Address: ________________________________________________

Transportation/bus pass
Agency ______________________ Phone: ________________
Address: ________________________________________________

Medical/dental care
Agency ______________________ Phone: ________________
Address: ________________________________________________
Prescriptions/medication
Agency ___________________________ Phone: __________________
Address: _______________________________________________________

Mental health care
Agency ___________________________ Phone: __________________
Address: _______________________________________________________

Substance abuse treatment
Agency ___________________________ Phone: __________________
Address: _______________________________________________________

Community support group referral
Agency ___________________________ Phone: __________________
Address: _______________________________________________________

Counseling for children/significant others
Agency ___________________________ Phone: __________________
Address: _______________________________________________________

Support for disability issues
Agency ___________________________ Phone: __________________
Address: _______________________________________________________

Pregnancy/Sexually Transmitted Infections Testing/Screening/Services
Agency ___________________________ Phone: __________________
Address: _______________________________________________________
Employment assistance
Agency ___________________________ Phone: ___________________
Address: __________________________________________________________

Child care
Agency ___________________________ Phone: ___________________
Address: __________________________________________________________

Education/training
Agency ___________________________ Phone: ___________________
Address: __________________________________________________________

Legal assistance
Agency ___________________________ Phone: ___________________
Address: __________________________________________________________

Spiritual needs (including rides to church, etc.)
Agency ___________________________ Phone: ___________________
Address: __________________________________________________________

Other: _____________________________
Agency ___________________________ Phone: ___________________
Address: __________________________________________________________

Other: _____________________________
Agency ___________________________ Phone: ___________________
Address: __________________________________________________________
PERFORMING A NEEDS ASSESSMENT

A needs assessment can be a nonthreatening way to glean information about co-occurring issues that may need intervention or referrals. The goal of a needs assessment is to ascertain ways your program can better serve an individual rather than to screen a person in or out of the program. When conducting the assessment:

The needs assessment should be done after individuals have been admitted to your program. Emphasize that the assessment will have no impact on shelter status or ability to stay in the program.

“Normalize” questions and find a way to discuss co-occurring issues that is comfortable for both of you. “Normalize” responses to traumatic situations, rather than pathologize the individual (Ferencik & Ramirez-Hammon, 2011).

Allow people who seek our services to tell us what they need and when, rather than assuming the “expert” role and telling them what they need. “When you’re working with people, allow them to take the lead,” says Olga Trujillo, Director of Programs at Casa de Esperanza in St. Paul, MN. “So when they come to you, they might be in a place to be able to deal with a certain issue, or they may not be in a place to be able to deal with it. They might just need crisis management. Or they might need something more than that. And they’re going to let you know” (Trujillo, 2009).

Ensure that people impacted by both interpersonal violence and co-occurring issues know about available resources. Explore options such as transitional housing, counseling, gender specific substance abuse treatment, support groups addressing multiple problems, children’s services, safety planning and linkage to other providers.

If lack of appropriate training or credentials prevents you from answering a question or providing a certain kind of assistance, explain this to the individual seeking your help. Make it clear you will help them figure out who can provide the needed help and are happy to explore options with them.

Use an interpreter when necessary. However, avoid using children, relatives of the abuser or people who do not understand confidentiality and domestic violence, sexual abuse and stalking issues.

An individual’s decision to decline treatment, advocacy, shelter or other services should not be viewed as failure. Supporting people through their process of change requires an understanding that motivation comes from within. Making changes is both an option and a process that can take time.

Understand the courage required to seek services. Convey to the people you serve that you appreciate their courage: “With all the stuff that’s going on for you, you still managed to do this. That’s fantastic” (Obtinario, 2010).
References


HOW DO WE ASK THOSE “STICKY” QUESTIONS?

Advocates and other providers are sometimes reluctant to ask about certain issues, lest they offend the people who come to them for help. Substance abuse may feel like a particularly touchy topic – especially if activities such as sex trafficking or illegal drug use are involved. Asking about mental health concerns or suicide risk may also feel tricky, and providers may fear risking legal problems if they ask about disability issues.

However, advocates may miss countless intervention opportunities if they are afraid to ask the important questions (Bland, 2001). And asking the right questions can even be life-saving. For example, advocates should always assess for suicide risk or potential for other self-harm (Pease, 2010).

The intervention is in the asking (Bland, 2001). Fortunately, there are respectful ways to raise sticky issues. Please note: These questions should NEVER be part of the initial screening process. Only ask these questions AFTER the decision has been made to admit a person into your program.

Regarding substance abuse, Cindy Obtinario, a chemical dependency/domestic violence specialist with New Beginnings in Seattle, WA, says: “The way we frame this questioning process is, ‘We are asking for this information not to screen you out, but to help support you in seeking safety, and to be able to give you the best referrals possible’” (Obtinario, 2010).

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 concerns or other personal issues. Asking open-ended questions can be helpful:

“What has worked well for you and what has given you problems?”

“Many people tell me a little alcohol helps take the edge off stress. How often has this worked for you?”

As another example, Farley (2003) stresses the need for questions regarding a history of exploitation by the sex industry. Unless screening questions such as these are asked, she says, this type of victimization will remain invisible. Questions she suggests include:

“Have you ever exchanged sex for money or clothes, food, housing, or drugs?” “Have you ever worked in the commercial sex industry: for example, dancing, escort, massage, prostitution, pornography, phone sex?”
While asking people with disabilities a question such as “Do you have special needs we should be aware of?” may feel disempowering, a more general question would be appropriate to ask anyone seeking services, whether they have a disability or not (Leal-Covey, 2011). Examples of general questions would include:

“Would you let me know if you need anything?” “Please feel comfortable asking if you need anything.”

If the individual has been a target for oppression due to misconceptions about race, culture, sexual orientation, disability or other status, consider how these other oppressions impact the experience of trauma and access to services. Also consider how the individual’s cultural background may have been a source of support. Questions suggested by Ferencik & Ramirez-Hammond (2011) include:

“What has worked for you in the past?”

“What has helped you within your culture and family of origin?”

Here are some additional examples of questions you can ask to better accommodate individuals participating in your program.

**Sample framing questions about abuse:**

“Women often report feeling stress in their relationship. How does your partner show disapproval?”

“Please describe any threats made by your partner. (How often? When was the last time? Were you afraid? Were you hurt? Can you tell me what happened?)”

**Sample framing statements:**

“Domestic violence and sexual assault are major problems for women. Because abuse is such a common experience for women, I ask everyone I see whether they feel safe.”

“Women in treatment often tell me their partners complain about their using. How does your partner show disapproval?”

**Sample indirect questions:**

“You mentioned your partner loses his temper with the kids. Can you tell me more about that? Have you ever felt afraid for yourself or your children? Can you tell me more about that?”
“All couples argue sometimes. Does your partner’s physical or sexual behavior ever frighten you?”

Sample questions if partner is user or abuser:

“How often do you find yourself using when you don’t really want to drink/drug/smoke alone?”

“When a partner spends family money on drug use, it is a form of economic abuse. Has your partner ever used food or rent money to drink or score drugs?”

Sample framing questions for substance abuse:

“What works best for you?”

“How often have you tried any of those ways of coping?”

“How often has that worked for you? Do you find it is still working?”

“Being involved in a court case/custody dispute can be stressful. Your partner may attempt to undermine you/your parenting skills. Can you identify any reasons why drinking or using drugs right now could be harmful to your case? Can you share with me what your partner might say about your drinking or drug use?”

Remember to ask direct questions tactfully and respectfully! These questions may help advocates and other providers identify accommodation needs for individuals using services. Answers to these questions are NOT used to screen people out. They are provided to help survivors address safety or health risks stemming from multiple abuse issues.

While advocates and other providers may hesitate to ask “taboo” questions because they fear giving offense, for many people seeking help, these same questions can send a positive message:

"It’s safe to talk about this issue here.”

When people are respectfully asked about substance use, mental health concerns and other issues that may impact their safety, they hear your message, even if they are not ready to enact change immediately. Often individuals will later share comments such as, “You know, when you said __________, it really made sense to me” (Bland, 2001).
References


Safety Plan

A safety plan is unique for each individual and may need to be revised as your situation changes. A safety plan is a tool. Below are suggestions others have found helpful. You are the best expert on your own situation. Some suggestions here may be useful for you, while others may not meet your needs. Feel free to add your own ideas. Take what you like and leave the rest!

The following steps will help you to prepare in advance for the possibility of future violence and will help keep you safer. Although you are not responsible for, nor do you have control over an abuser’s violence, you do have a choice about how to respond to the abuser, and how best to get yourself (and your children) to safety.

Staff will support you in the decisions that you make for your life. Your physical safety will always be a priority for us. Hopefully, one or more of the following steps will help you in safety planning.

STEP 1: Safety During a Violent Incident

If I feel the abuser is about to be violent, I will try to move to the ______________. (Try to avoid the bathroom, garage, kitchen, places near weapons, or rooms without access to the front door.)

If it's not safe to stay, I will ______________. (Practice how to get out safely. What doors, windows, elevators, or stairwells will you use?)

I will keep my bag ready and keep it ______________ in order to leave quickly.

I will tell ______________ about the violence and ask them to call the police if they hear suspicious noises coming from my home.

I will use ______________ as my code word/phrase with my children or my friends so they can call for help.

If I leave my home, I will go to ______________ (Keep a list of emergency numbers in your purse or wallet.)

I will remember that if I call 911 and leave the phone off the hook, the domestic violence incident will be tape-recorded and an officer should respond to the scene.

Remember, you know your abusive partner best. You know how to protect yourself and your children better than anyone else.

STEP 2: Safety When Preparing to Leave

I will leave money and an extra set of keys with ______________ so I can leave quickly.

If I own a car I will try to make sure that I keep a set of car keys with ______________ and enough gas in the car.
I will open my own bank account by ___________________________ (date) to increase my independence.

I can also begin to ___________________________ as a way of increasing my safety and independence.

I will memorize the 24-hour crisis line of the agency closest to me. That number is ___________________________. I will keep the number in my wallet along with a quarter (if possible).

I will check with ___________________________ and ___________________________ to see if I could stay with them in an emergency (It is best if the abuser does not know them or where they live.)

I will review and update my safety plan.

**STEP 3: Safety in My Own Home**

I will find a safe place to keep this plan.

If my abuser has recently left, I will change the locks on my doors and secure locks on my windows as soon as possible.

I will tell school and/or child care who has permission to pick up my children.

I will tell my neighbors if my abusive partner no longer lives with me and ask them to call 911 if they are seen near my home.

If there are weapons (guns, knives, etc.) in my house, I will try to remember:

- to make sure that the gun remains unloaded at all times (I will only unload the gun myself if I know how to do so safely!!)

- to encourage my partner to get rid of the gun if it is safe for me to do so.

- to stay out of rooms where weapons are kept, especially during an explosive situation.

- to move the knives out of their usual location so that my partner will have trouble finding a knife quickly.

- that almost anything can be used as a weapon.

- that cleaning a gun or knife in front of me is a threat and may imply that my partner is capable of taking my life or hurting my children.

**STEP 4: Safety With a Protective Order (or other court order)**

I will keep an emergency copy ___________________________.

My children’s teachers and babysitters will have copies of the order.

If my partner violates the order I will call the police.

If the police are not responsive I will ___________________________.
I will tell ______________________
that I have a valid Protective Order.

Remember that in the State of Alaska, if your partner assaults you when you have a valid Protective Order, your partner can be charged with a crime.

**STEP 5: Safety on the Job and in Public**

I will inform ______________________
at work of my situation, if I feel safe with this person. I will ask ____________ to help screen my calls at work.

When leaving work, I will ______________________ to help keep myself safe.

If problems occur while I am driving home, I will ________________.

If I ride the bus and see my abuser, I will ________________.

**STEP 6: Safety and My Emotional Health**

When I have to talk to my (ex) partner, I will ________________ to keep myself safe and take care of myself.

I will read ______________________

I will call ______________________
for support.

I will call my local crisis line or other support system if I need immediate help. That number is ________________.

I know that community support groups are available to help me take care of myself.

**STEP 7: Safety and Sobriety**

I will remember it is easier to keep safe when I am sober.

I know that alcohol and drug use can impair my judgment and make it harder for me to choose safe options and access services.

I will call my local DV/SA advocate or the National Domestic Violence Hotline 1-800-799-7233 or the Rape Abuse Incest National Network (RAINN) 1-800-656-4673 when I need information, referrals or support.

I will call a sober friend, sponsor, alcohol/drug counselor or a local alcohol-drug 24-hour help line for support when I feel like drinking or drugging to cope. The help line number is ________________.

**PERSONAL SAFETY NOTES:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

This safety plan is adapted from New Beginnings and Providence Health System safety plans.
Children Affected by Domestic Violence and Substance Abuse

Author’s note: Below are some considerations to take into account when working with children affected by both domestic violence and substance abuse, including substance abuse coercion. Appropriately responding to the needs of children experiencing any type of harm or abuse requires knowledge of the children’s developmental stage as well as their capacity to seek and obtain safety. It also requires knowledge of available resources as well as mandatory reporting guidelines in your state. For additional resources related to children see the NCDVTMH webpage on Supporting Children, Parents and Caregivers Impacted by DV:


1. Violence occurs against both adults and children in the same family.
   a. Witnessing domestic violence and substance abuse can affect children and put them at risk for harm.
   b. While not the norm, severe and fatal cases of child abuse may sometimes occur in homes where domestic violence and/or substance abuse overlap.

2. Many people who physically or sexually abuse or neglect children also abuse their partner who is often the children’s mother.

3. Some children who witness domestic violence are affected the same way as children who are physically or sexually abused.

4. In spite of what those who harm others (perpetrators) and non-offending parents say, children have often either directly witnessed the physical and psychological assaults or have indirectly witnessed them by overhearing the episodes or seeing the aftermath of injuries and property damage. They are often all too aware of the impact of substance abuse in their family as well.

5. Children affected by domestic violence and/or substance abuse do not experience a carefree childhood and may act adult while they are children. They may be busy surviving, placating, picking up pieces, adjusting and adapting just to stay alive.
Tactics of Abuse

People who harm and abuse their partners (domestic violence perpetrators) pose the following risks to children. They may:

1. Harm children by coercing them into abusing their mothers or other adult caretakers.
2. Endanger children emotionally and physically by creating environments in which children witness assaults, including substance abuse coercion, directed against their mothers or others.
5. Endanger children through neglect.
6. Focus so much attention on controlling and abusing their adult partners they ignore and neglect children.
7. Prevent adult victims of domestic violence from caring for children resulting in neglect.
8. Endanger children by undermining the ability of providers to intervene and protect children.
9. Endanger children by exposing them to the effects of alcohol and other drug abuse as well as the effects of substance abuse coercion.

Those who harm their partners (abusers) also traumatize children in the process of battering their adult intimate partner. They do so by:

1. Intentionally injuring the children as a way of threatening and controlling the abused parent. (For example, the child is thrown at the victim).
2. Unintentionally injuring the children during an attack on the abused parent when the child gets caught in the fray. (For example, the infant is injured when the mother is struck while holding the infant).
3. Using children to coercively control an abused parent while living with or separated from the abused parent. The intent is to continue abusive control over their partner with
little or no regard for the damage done to the children. *(For example, the child is asked to report who mommy talked to.)*

4. Creating an environment where children are forced to witness domestic violence and/or substance abuse, substance abuse coercion and their effects.

Examples of behavior by a person who is abusive *(perpetrator)* that traumatizes children include:

1. Asserting that children’s "bad" behavior is reason for their drinking, drugging or violence directed at their parent or other caregiver.

2. Threatening pets, loved objects, toys, etc.

3. Isolating children, banning friendships.

4. Interrogating children about the victim’s activity.

5. Forcing the victim to always be accompanied by the children.

6. Holding the children hostage.

7. Using lengthy custody battles as a means to continue abusing the victim; demanding unlimited visitation or 24-hour access by phone; threatening to report the victim to the Office of Children’s Services (OCS) for past alcohol or other drug use.
Safety Planning Interventions for Children

Author’s note: Below are some considerations to take into account when working with children affected by both domestic violence and substance abuse, including substance abuse coercion. While children as young as 3 and 4 can often be taught elements of safety planning, young children and infants are at greatest risk for harm. Appropriately responding to the safety planning needs of children witnessing or experiencing any type of harm or abuse requires knowledge of the children’s developmental stage as well as their capacity to seek and obtain safety. It also requires knowledge of available resources as well as mandatory reporting guidelines in your state. For additional resources related to children see the NCDVTMH web page on Supporting Children, Parents and Caregivers Impacted by DV:

See also “Safety Planning with Children,” a video developed by the AWARE Shelter in Juneau, Alaska marketed by Intermedia. To preview a copy of this video see the following website: http://www.intermedia-inc.com/title.asp?sku=SA13&subcatID=87

It’s important to safety plan.

Children:

- Are at risk and need to be safe.
- Often blame themselves for both the violence and the substance abuse.
- Feel terrified and helpless; angry and sad.
- Wonder, “What can I do?” and “What should I do?”
- Need something to ease the negative impact of domestic violence and substance abuse on their lives.
- Need the power that comes from knowledge of how to keep safe.

Safety planning with children:

- Gives them skills to protect themselves.
- Helps them feel confident.
- Empowers them.
• Gives them a reality check.

• Breaks isolation.

• Helps keep them safe.

**You can help develop a safety plan to protect your children.**

A safety plan should include:

• How your child can escape from the house if an assault is in progress or drinking/other drug use is scaring them.

• Where to go in an emergency.

• How to call police (explain 911 – how to call and what happens when you call. Let them know if you or someone else in the house is being hurt or is unconscious or passed out from drinking or drug use, it is ok for them to hide in a safe place and call 911 or to call a safe adult for help).

• How to call supportive family members, friends and community agencies for help.

**You can help your children.**

• Listen.

• Provide structure, consistency.

• Tell your children it is important for them to be safe. If you are being assaulted, they should not intervene or put themselves in harm’s way.

• Reassure children that domestic violence and/or substance abuse is not their fault and that blaming themselves is a common reaction.

• If your child is called on to testify, develop a plan to support the child over issues of fear, anxiety, divided loyalties, painful memories.

• Call your local domestic violence/sexual assault victim service program and substance abuse treatment program to get information about services for children.
• Practice the safety plan with your children.

• Ensure at least one adult provides unconditional positive regard.

• Let your children know it is OK to talk about family violence and/or substance abuse.

• Provide positive messages as well as safety planning. (*For example: "Violence is not your fault. Neither is drinking or drug use.") Let children know anger doesn’t need to lead to violence or substance abuse.

• If your children are drinking, drugging, suicidal, homicidal or violent towards other family members, develop a plan for their safety and the safety of others. Set clear limits with children who are violent and abusive or using substances themselves. Refer them to appropriate services.

• Help kids be kids. Provide after school options, encourage them to participate in children’s programs. If your community does not have one, explore forming an Alatot or Alateen program. Find out what children’s resources are available at your local domestic violence/sexual assault program.
ADVANTAGES OF WORKING WITH OTHER PROVIDERS

Working with people impacted by multiple issues requires the inclusion of providers from diverse backgrounds and disciplines. Working in partnerships, collaborations, and coalitions with other community providers offers several advantages for everyone involved:

Working in partnership with others, while challenging, can be a powerful tool for mobilizing individuals and groups to action, bringing community issues to prominence and developing policies (Cohen, Baer, and Satterwhite, 2002).

Community coalitions and collaborations can help everyone remain up to date on what other providers are doing regarding a particular issue, as well as what resources are available in the community to address the issue (Cohen and Gould, 2003).

Rather than creating new projects or programs, such associations can help everyone avoid duplication of services, and thereby avoid wasting scarce resources (Cohen, Baer, and Satterwhite, 2002).

Effective coalitions can accomplish a broad range of goals that reach beyond the scope and capacity of any one single institution or organization (Cohen & Gould, 2003).

More and more, funders are requiring that provider groups work together to solve a problem (Cohen & Gould, 2003).

Perhaps most importantly, establishing relationships with a variety of other providers can help

A survivor of multi-abuse trauma tells how she benefited from a relationship between a domestic violence agency and a dentist:

“There’s a program called Give A Smile Back, and it’s pro bono. You had to have damage done to your teeth by domestic violence. They are putting several thousand dollars worth of work in my mouth, and they are giving me my smile back.”
all of us provide more and better services. A survivor shares the impact on her when a domestic violence agency developed an ongoing relationship with a dentist in the community:

“There’s a program called Give A Smile Back, and it’s pro bono. You had to have damage done to your teeth by domestic violence. They are putting several thousand dollars worth of work in my mouth, and they are giving me my smile back.” *Advantages of Working with Other Providers* 2

Partnerships and collaborations also can help us improve our outreach efforts. Erin Patterson-Sexson, Lead Advocate/Direct Services Coordinator at Standing Together Against Rape (S.T.A.R.) in Anchorage, AK, says:

“We go into the psychiatric institute and the correctional facilities, and work closely with our forensic nurses. We have great connections with our military branches. We have a strong partnership with our school district. Those have all been helpful tools in not only spreading our preventive education, but also connecting with survivors.”

**References**


CREATING ALLIANCES

When working with people impacted by multiple issues, cooperation with other community providers and systems is essential. Cultivating relationships with other providers is well worth the time and effort, according to providers who have been successful in this regard.

Paula Lee, Shelter Coordinator at South Peninsula Haven House in Homer, AK, says:

“We’re really connected with all of the services here in Homer. I’ll call Mental Health, and usually they have a waiting list, but if the person is someone we’re serving here, they’ll put them on a priority list for cancellations. We have an independent living center here and if survivors have a disability or are elders, they’re put on a fast track. We also have the homeless prevention project, and if we’re really packed and can’t take a homeless person in, they’ll put them up in a hotel” (Lee, 2010).

Shirley Moses, Shelter Manager at the Alaska Native Women’s Coalition in Fairbanks, AK, describes the partnerships her agency has created:

“We partner with whatever agency or village wants us to go in. I’m also part of the Women’s Community Coalition staff, and we have typically had some money to go and do domestic violence and sexual assault prevention, training, and response. Our villages and regional hubs or statewide agencies, Native and non-native, ask us to do trainings. We go in with a lot of prior planning. They self-identify what they want. If they want to focus on domestic violence, we go in and we might have planning meetings with whoever the village identifies as their contact person, talking about what domestic violence issues they have, and then we coordinate with them and set up a talking group. They identify people they would like to have attend our training, usually three to four days in a location that is agreed upon by everyone that is going to attend. We have gone to small villages. We partner with our public health nurses, our mental health providers. A lot of our villages have mental health advocates. We work with them and their supervisors and their clinicians, the troopers, whoever the village or region or hub identifies as people who can address domestic violence issues. We do the DV 101, usually, and historical trauma, and the effects of domestic violence on children. Then we do brainstorming, break into small groups, and they are the ones who identify strengths, needs, and barriers. And then they try to come up with solutions or ways that they can develop safe homes, what kind of safety net would work in their region or village. They are really creative” (Moses, 2010).

When working with other providers:

Conduct trauma-informed education for both advocates and other providers to increase everyone’s knowledge and understanding of the prevalence of trauma, re-
traumatization, and coping adaptations (and their negative consequences) by individuals who have experienced trauma. Establish a universal presumption of trauma, recognizing that it could be part of the life experience of anyone with whom we interact (National GAINS Center, 2006).

All providers need training to recognize co-occurring issues and make appropriate referrals. Agencies can provide education and cross-training in partnership with each other. Develop community partnerships or work groups to address these issues together. Brown bag lunches and Peer Review while maintaining confidentiality can be helpful.

Acknowledge controversies rather than pretending they don’t exist – “wounded healers” vs. “professionals,” “peers” vs. “experts,” theoretical differences, etc. Training should address dealing with conflict stemming from philosophical differences among multiple helping systems and emphasize the importance of working together for the benefit of individuals who receive our services.

When encountering providers with different priorities and philosophies, it may help to find areas of agreement first, then work on addressing philosophical differences. Cindy Obtinario, a chemical dependency/domestic violence specialist at New Beginnings in Seattle, WA, finds that it helps to explore the “why” behind the other provider’s philosophy by first asking questions:

A survivor of multi-abuse trauma shares her experience with a helping professional who wasn’t trained about substance use disorders:

“They’d say, ‘You just need to watch your drinking and don’t get so carried away with it.’ Well, that doesn’t work with alcoholism. I kept trying to do it right, I’m telling you! And I tried to ‘do it right’ for years.”
“I give them the opportunity to explain their philosophy, and then ask them, ‘Could you consider this?’ And after they’ve had their opportunity to share, then I’ll present mine. I explain that the domestic violence movement is based on empowerment, and we believe that each woman solves her own problems in her own way and time, and each woman is responsible for her own conduct. If you need to monitor progress and conduct in your program, I understand, but that’s not what we do here” (Obtinario, 2010).

When seeking to resolve differences, choose your battles. Is the “difference” truly harming someone we serve? Can the providers “agree to disagree” on some issues such as language or terminology?

**WHAT DO WE NEED TO KNOW?**

Advocates and other service providers cannot be expected to know everything, and we don’t need to be an expert on everything. But here’s what we do need to know:

- How to recognize signs that a person we are serving may have a problem other than the one we’re trained to deal with.
- How to recognize when a person has problems other than the problem they are seeking services or treatment for.
- What resources are available in the community so we can make appropriate referrals.
- How to get word out about our own services so others in the community know we exist and know what we have to offer.
- How to establish working relationships with other providers to ensure a continuum of care.

Do not imply that other social service providers are bad people, or negligent in some way. They may be unable to provide certain services for valid reasons, such as ethical concerns about providing services beyond their level of expertise.

Focus on what we can learn from each other. Assume that we can benefit from the other provider’s knowledge as much as they can from ours.

As human beings, we tend to be resistant to learning things from people who don’t want to
Learn from us. That’s just human nature.

Respect the professional expertise that each party brings to the table. This means sharing what we know and, just as importantly, asking for help and information in areas where our own knowledge base is lacking. For example, most victim’s advocates are not experts on mental health care and, conversely, most mental health care providers are not experts on domestic violence. We do not have to be “experts” in each other’s fields, but we do need to recognize and capitalize on each other’s expertise (Nudelman & Rodriguez Trias, 1999).

Recognize the limits of each philosophy or theoretical orientation. Karen Foley is a behavioral health specialist and 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 it’s extremely important to look at different approaches for the different issues. For example, I believe that if you try to treat domestic violence through the lens of addiction, using a medical model, you will do a disservice. For example, trying to get someone to accept responsibility for things that are not theirs to own is a form of victim blaming. And the same is true if you try to solely use an empowerment model when somebody is dealing with addiction. Then the provider can miss the boat in being able to help” (Foley, 2010).

Hold abusers accountable for their behavior and encourage other providers to do so as well. Don’t blame victims of domestic violence, sexual assault, stalking or other forms of abuse for the harm that has been done to them or the tools they have used to cope. Remember, in many cases abusers have fostered substance use and created stress and trauma for the people they have hurt and abused.

References


Even when priorities and philosophies are different, this doesn’t mean advocates must compromise our own standards to work effectively with other providers. Nor is it necessary for other providers to compromise their standards or priorities to work effectively with us. When working with other providers, keep in mind:

Different issues may require different priorities and different approaches. For example, it’s perfectly appropriate that an advocate would be focused on safety for victims of violence while a substance abuse counselor focuses on sobriety for people with substance use disorders, a child welfare caseworker focuses on the best interest of children and a criminal justice professional focuses on community safety. Karen Foley of Triple Play Connections says:

“It’s really important to learn more about the other issues, and even if you don’t agree, to understand why different philosophies and different models are practiced. I’ve found that the most beneficial thing I can do is listen rather than talk. I’ve come a long way in understanding that it’s really important to look at each issue separately, and to understand and learn the value of each approach. So when do you use the medical model versus the empowerment model? And when are you looking at a mental health issue versus a chemical dependency issue versus an oppression issue? I think it’s very important not to only look through one lens, but to understand the philosophical differences and when you apply them to what issues” (Foley, 2010).

A key to reconciling differing priorities is to take a both/and approach rather than an either/or approach, so that priorities and philosophies are not necessarily seen as being in conflict with each other. For example, an advocate’s priority of helping a parent get safe from violence is certainly compatible with a child welfare caseworker’s priority of protecting the best interest of the children. Karen Foley offers another example:

“The medical model is really, really important when dealing with addictions, because we know that it’s a body change, that the body is different in somebody who’s addicted or alcoholic versus someone whose body does not respond to alcohol or other drugs in the same way. So there are chemical changes that have happened. It’s not about being a bad person. It’s about having a bad disease. On the opposite end, when you try to solely use an empowerment-based model on someone who is dealing with the disease of addiction, they don’t get help for their addiction, and often end up back in an abusive situation” (Foley, 2010).

Individual counselors or other professionals within the same discipline may also have differing approaches and philosophies. It may be possible to find professionals in each discipline whose philosophies are compatible with your own. Cultivate relationships with these individuals for the purpose of making referrals.
A WORD ABOUT LANGUAGE

While it’s important not to dilute our own message, there are steps we can take to improve communication with other providers across disciplines:

Avoid jargon. Each discipline has a tendency to create its own brand of alphabet soup. Terms like DART, TRO, OP, MISA, IEP or WRAP may not make sense to people outside your own discipline. If someone else uses acronyms or jargon, don’t be afraid to ask what they mean.

Try to get past “language” differences and listen for the content of what the other person is saying. If you have a preferred term (“program participant” vs. “client,” for example), use your own language when talking with other providers, but do not insist that others use it.

Learning some of the common terms used by other providers – and incorporating some of their language where possible – can aid in building bridges rather than fences.

Here are some examples of types of providers, along with ways to reconcile their philosophies and priorities with your own for the benefit of the people you both serve:

Substance abuse counselors. In recent years, a number of substance abuse counselors have begun moving away from the heavily confrontational approaches that were once popular in treatment centers (Obtinario, 2010). Some counselors employ motivational interviewing, an approach which helps people change harmful behavior such as alcohol or drug abuse by exploring and resolving the ambivalence most people feel when they seek to make major changes in their lives (Rollnick & Miller, 1995). Emphasis is on respecting individuals’ right to make their own decisions as they are ready to do so, which makes the approach compatible with the empowerment approach favored by victims’ advocates. Many treatment programs also offer gender-specific programs, which may be more appropriate for women with interpersonal violence issues (IDHS, 2000).

Mental health providers: Advocates who work with domestic violence and sexual assault survivors often come from a social justice perspective and employ the advocacy model, which emphasizes safety and empowerment, support and access to resources, accountability for abusers and perpetrators, and social change (Warshaw, 2010). Mental health providers, on the other hand, often employ a clinical model, which focuses on identifying and relieving symptoms that interfere with an individual’s quality of life or ability to function.
But Warshaw (2010) points out that common goals of advocates and mental health providers include health, safety, freedom and connection. Also, an increasing number of mental health professionals have recognized the need for trauma-informed care, which is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and the prevalence of these experiences in persons who receive mental health services (Huckshorn, 2004). Develop relationships with mental health providers whose approach emphasizes trauma-informed care, particularly those familiar with and experienced with complex trauma.

Disabilities advocates: Many providers are concerned about the expense that might be involved in making facilities and services accessible to people with disabilities. However, increasing accessibility need not always be an expensive proposition, says Christine King at the University of Alaska Center for Human Development, who has worked in the field of disabilities for more than 18 years. Sometimes improving accessibility may be as simple as relaxing a policy or rule, or giving someone more time to complete a task or goal. King adds that disabilities advocates are eager to offer their assistance to providers with questions about how to make their services more accessible (King, 2009).

Indigenous providers: Differing patterns of caregiving across racial and ethnic groups strongly underscore the need for culturally relevant services (Nicholson et. al., 2001). The dominant culture’s social service system tends to promote individualism over collectivism, and many Western practitioners embrace a medical model for healing while indigenous cultures may believe that health is attained through the harmony of mind, body and spirit (Comas-Diaz, 2007). Some advocates and other professionals are uncomfortable with issues of religion and spirituality, while many persons

A survivor of multi-abuse trauma discusses the importance of working with indigenous providers:

“What has been helpful for me is interacting with elders of my village, elders within my region. Elders are individuals with many years of experience. They’re not judgmental or critical. They have big elephant ears ready to listen. I had to go back to my own Alaska Native values.
from marginalized groups view adherence to spiritual practices as resilience against adversity (Comas-Diaz, 2007). Advocates should collaborate with indigenous providers, when available. Recognize and enlist the assistance of recognized helpers such as indigenous healers and elders.

Also provide cross-training for all providers on diversity issues. Get to know the cultures in your area and invite people from these cultures to provide training for staff.

**Child welfare workers:** The number one priority for child welfare workers is to protect the best interests of children who are at risk of harm. Domestic violence increases the risk of child abuse and neglect, especially when substance abuse is involved (IDHS, 2000). Even if they are not intentionally targeted for abuse, children in a home where a parent is being battered are often injured while trying to intervene in a violent incident. And even when children are not physically abused themselves, they still often suffer the traumatic effects stemming from exposure to batterers. Advocates and other providers are mandated to report child abuse and/or neglect to their state’s child welfare agency. When child abuse or neglect is suspected, a thorough physical and psychological assessment may also be necessary, as well as other services. Advocates, substance abuse counselors, mental health professionals and child welfare caseworkers should also collaborate to ensure that children exposed to batterers (and their non-offending parents or caregivers) receive resource information and a safety plan.

**Criminal justice personnel:** When working with a survivor of multi-abuse trauma who is, or has been, incarcerated, keep in mind that preventing recidivism is a priority for most criminal justice professionals. Studies repeatedly show safe housing, employment and appropriate social services are critical to reducing recidivism for these individuals (Covington, 2002). Many survivors suffered traumatic experiences in their lives long before they developed the coping mechanisms that may have led to their incarceration or other involvement with the criminal justice system. Emphasize that helping survivors get the help they need to heal from past abuse or trauma can go a long way toward reducing recidivism.

**References**


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


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


Appendix: Resources
Resources

The resources below include webinars, tip sheets, policy guides and other materials developed by the National Center on Domestic Violence, Trauma and Mental Health (NCDVTMH). We also include links to the Real Tools family of products from the Alaska Network on Domestic Violence and Sexual Assault (ANDVSA), which offers more than three dozen handouts suitable for photocopying and using with support groups or trainings (in both English and Spanish), a variety of Power and Control Wheels, and lists of additional useful materials. Vignettes or “survivor stories” are contained in many of the following materials based on interviews by NCDVTMH staff member Patti Bland and NCDVTMH consultant Debi Edmund. They are also sprinkled throughout the various webinars and documents provided here to help illustrate the concepts presented. (Note: To protect the confidentiality of the survivors we interviewed, no real names have been used.)

Links to other sites that have developed materials designed to support advocates and providers serving survivors experiencing substance abuse, trauma, and psychiatric disabilities are also listed below. These include training materials, manuals and policy guidelines from British Columbia, Illinois, Iowa, and Texas. Links to resources addressing sexual assault and substance use, historical trauma, collaborative service provision, gender responsive treatment and other information are also available, including links to webinars and other information from the National Indigenous Women’s Resource Center, Praxis, Substance Abuse and Mental Health Services Administration, and VAWnet.

Our NCDVTMH webpage is a work in progress. We hope to continue bringing you an ever-growing array of helpful trauma-informed tools, links, and information to help reduce service barriers for DV/SA survivors experiencing harm from intimate partners using substance abuse coercion against them. We also seek to offer options to help advocates and providers reduce service barriers for survivors coping with abuse through substance use or abuse.

Remember to keep coming back...!

1. **National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH)**

NCDVTMH Online Training and Resource Center:
http://www.nationalcenterdvtraumamh.org/trainingta/

For free Webinars on a variety of topics:
http://www.nationalcenterdvtraumamh.org/trainingta/webinars-seminars/

**Other NCDVTMH Resources:**

Locating Mental Health & Substance Abuse Supports for Survivors: A Reference Sheet for Domestic Violence Advocates
Model Medications Policy

Special Collection: Trauma-Informed Domestic Violence Services (contains several resources addressing the intersection between domestic violence/sexual assault and substance abuse)

Safety and Well Being Tip Sheet Series: Substance Abuse and Mental Health Coercion

2. **Real Tools Series of Products from the Alaska Network on Domestic Violence and Sexual Assault.** By Debi Edmund, M.A., LPC and Patti Bland, M.A., CDP, with Spanish translation by Cecilia Leal-Covey, M.Ed., AET.

Real Tools – Responding to Multi-Abuse Trauma – Full Manual 2011 Edition (English)

Real Tools – Responding to Multi-Abuse Trauma – Click It and Print Version 2012 Edition (English)
http://www.andvsa.org/realtoolsprint/

Real Tools: Responding to Multi-Abuse Trauma – 2011 Edition (Spanish)

Getting Safe and Sober – 2008 Edition (English)

Getting Safe and Sober – 2008 Edition (Spanish)

3. **Resources from the BC Society of Transition Houses, British Columbia, Canada**

Reducing Barriers to Support for Women Fleeing Violence: A Toolkit for Supporting Women with Varying Levels of Mental Wellness and Substance Use


Safety and Sobriety Manual Best Practices in Domestic Violence and Substance Abuse, January 2005
http://www.dhs.state.il.us/page.aspx?item=38441

5. Iowa Coalition Against Domestic Violence and University of Northern Iowa Integrative Services Project:
http://www.icadv.org/%23integrative-services-project/c1c82

6. Great Lakes Addiction Technology Transfer Center (ATTC)
Addiction Recovery and Intimate Partner Violence: A Self-Paced On-Line Course
http://www.attcnetwork.org/regcenters/generalContent.asp?rcid=3&content=STCUSTOM2

Substance Abuse Recovery and Domestic Violence: A Great Lakes ATTC Initiative Interim Project Report, Larry Bennett, PhD and Priti Prabhughate, M.Ph., Ph.D. student, Jane Addams School of Social Work, University of Illinois at Chicago, 2009
http://www.nattc.org/userfiles/SARDV%20Needs%20Assessment%20Final%20Report%20April%202009%205B1%5D.pdf

7. Rape Abuse and Incest National Network (RAINN)
Substance Abuse
http://www.rainn.org/get-information/effects-of-sexual-assault/substance-abuse
8. SafePlace, Ending Sexual and Domestic Violence, Austin, TX

Beyond Labels: Working with Abuse Survivors with Mental Illness Symptoms or Substance Abuse Issues This manual provides information, tools and resources for domestic violence and rape crisis center staff to better understand the connection between mental health and trauma. Readers will be better able to work with survivors experiencing mental health and substance abuse issues and how to create a center more welcoming to these survivors. For more information and to order a copy, contact SafePlace: http://safeplace.org/about/programs-and-services/disability-services-asap/materials/

9. National Center on Domestic and Sexual Violence

This organization provides training and technical support for a myriad of professionals who work in multiple disciplines.

NCDSV also has an extensive list of resources addressing domestic violence/sexual assault and substance abuse.
http://www.ncdsv.org/publications_substanceabuse.html


Praxis International, Inc. works towards the elimination of violence in the lives of women and their children. It is the mission of Praxis International to join with other progressive social change organizations and programs to work toward the elimination of oppression in our society.


11. Stephanie Covington, PhD LCSW

Gender-Responsive and Trauma-Informed Services http://www.stephaniecovington.com/

12. Substance Abuse and Mental Health Services Administration (SAMHSA)

Home Page http://www.samhsa.gov/

Domestic Violence http://store.samhsa.gov/pages/searchResult/Domestic+Violence

Gender Responsive Treatment for Women http://store.samhsa.gov/pages/searchResult/gender+responsive+treatment+for+women

Sexual Assault http://store.samhsa.gov/pages/searchResult/Alcohol+and+Sexual+Assault

Trauma-Informed Care http://store.samhsa.gov/facet/Treatment-Prevention-Recovery/term/Trauma-Informed-Care
13. Scott, Hampton, Psy. D.
Alcohol and Sexual Assault
http://www2.potsdam.edu/alcohol/Controversies/1109127234.html#.U4kt7rVOVMs

http://www.tripleplayconnections.org/

15. UAA Justice Center – University of Anchorage, Alaska
Justice Center Publications and Papers: Sexual Assault http://justice.uaa.alaska.edu/a-z/s/sexual_assault.html
Sexual Assault Nurse Examinations in Alaska, Andre Rosay and Tara Henry
http://justice.uaa.alaska.edu/forum/25/1-2springsummer2008/e_sane.html

16. Amnesty International
Sexual violence against Indigenous women is the result of a number of factors and continues a history of widespread human rights abuses against Indigenous peoples in the USA. See link to “Maze of Injustice” below for more information.

17. The National Indigenous Women’s Resource Center, Inc. (NIWRC)
NIWRC is a Native nonprofit organization created specifically to serve as the National Indian Resource Center (NIRC) Addressing Domestic Violence and Safety for Indian Women Home Page: http://www.niwrc.org/
Article: Alcohol and Sexual Violence Perpetration, Antonia Abbey with contributions from Lydia Guy, 2008.
Webinar: Safety and Sobriety: Supporting Survivors of Substance Abuse, Trauma and Gender Violence, Patricia J. Bland M.A. CDP, National Center on Domestic Violence, Trauma and Mental Health
http://www.youtube.com/embed/dQIJ2LhPywY?autoplay=1&hd=1&rel=0&KeepThis=true&TB_iframe=true&height=370&width=640?autoplay=1&hd=1&rel=0
Webinar: Working with Women who are Victims of DV and Substance Abuse, Brenda Hill, Native Co- Director, South Dakota Coalition Ending Domestic & Sexual Violence
http://www.youtube.com/embed/0Re-2rnsMxc?autoplay=1&hd=1&rel=0&KeepThis=true&TB_iframe=true&height=370&width=640?autoplay=1&hd=1&rel=0
18. VAWnet.org

Models from Mental Health and Substance Abuse Settings: Trauma-—Informed Domestic Violence Services
http://www.vawnet.org/Assoc_Files_VAWnet/TIC-Models.pdf

Substance Abuse and Intimate Partner Violence, Larry Bennett & Patti Bland. 2008 (May)

Substance Abuse and Women Abuse by Male Partners, Larry Bennett, PhD 1997

Using Trauma-Informed AOD Treatment Practices to Improve Outcomes for African-American Survivors of Domestic Violence

19. White Bison, Inc. - The Wellbriety Movement Partners

This is a Native American program that facilitates the Wellbriety movement. See website for culturally relevant material and links for training on historical and intergenerational trauma and other topics and resources.
http://www.whitebison.org/index.php

20. Washington State Coalition Against Domestic Violence

Resources including Fatality Review Reports with recommendations for advocates, substance abuse counselors, mental health professionals and other behavioral health providers to better respond to the needs of survivors experiencing numerous barriers including substance abuse.
http://wscadv2.org/resourcesalpha.cfm

See also information about the Women in Recovery Caucus of WSCADV:
http://wscadv2.org/projects.cfm?aid=e352656b-c298-58f6-0925ed68fb044d14
Home page: http://wscadv2.org/whatwedo.cfm

21. Ohio Domestic Violence Network

Link to practical updated version of Trauma-Informed Care: Best Practices and Protocols for Ohio’s Domestic Violence Programs. Updates and revisions were made by ODVN Training Coordinator Rachel Ramirez, MA, LISW-S, co-author of the original manual.

*Note: The *Trauma-Informed Substance Abuse Training and Technical Assistance Program* web-site is supported by Grant No. 2011-TA-AX-K128 awarded by the Office on Violence Against Women, US Dept. of Justice, and the Family Violence Prevention and Services Program Administration on Children Youth and Families Administration for Children and Families, US Department of Health and Human Services. The opinions, findings, conclusions and recommendations expressed in these webinar presentations are those of the author and do not necessarily reflect the views the US Department of Health and Human Services or the Dept. of Justice, Office on Violence Against Women.*
About the Authors

**Patti Bland, M.A., CDP,** was the Director of Substance Abuse Training and Technical Assistance at the National Center on Domestic Violence, Trauma & Mental Health. Ms. Bland has served as both a shelter-based advocate at New Beginnings for Battered Women and their Children and a chemical dependency counselor for over 20 years. She developed the Domestic Violence/Chemical Dependency Outreach Project for King County at the Alcohol Drug Help Line in 1994 and served as the original Trainer for Providence Health System’s Family Violence Program in Washington State. She directed the Training Project for the Alaska Network on Domestic Violence and Sexual Assault (ANDVSA) in Juneau for ten years, as well as provided training and technical assistance nationally.

Ms. Bland has published several articles on substance use and violence against women. She has also developed domestic violence curricula for the Washington State Medical Association and the Perinatal Partnership Against Domestic Violence. She is the author of ANDVSA’s Curriculum for Advocates and co-author, with Debi Edmund, of *Getting Safe and Sober: Real Tools You Can Use* and *Real Tools: Responding to Multi-Abuse Trauma.*

**Debi S. Edmund, LPC, CADC,** is a certified alcohol and drug counselor, a trained domestic violence advocate and a licensed professional counselor. She has several years of experience working with people presenting with multiple issues – among them, interpersonal violence, substance abuse, mental health issues and homelessness. She has worked in a drug and alcohol treatment center, a domestic violence shelter, a behavioral health center and a transitional living program for survivors of sex work, as well as a re-entry program for incarcerated women returning to the community.

She was a member of the Domestic Violence/Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services from 1999-2004, where she served as editor of *Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse.* She also is co-author and editor, with Patricia Bland, of *Getting Safe and Sober: Real Tools You Can Use* and *Real Tools: Responding to Multi-Abuse Trauma,* both published by the Alaska Network on Domestic Violence and Sexual Assault.