

A Strength-based Approach Toward Trauma-informed Treatment and Recovery Support for Women

Workshop delivered at the MI-PTE Fall Conference, 2011, by Pamela Woll, MA, CADP, Great Lakes Addiction Technology Transfer Center

The following notes were compiled by Pam Woll as a post-session handout for this workshop. They were gathered from a number of sources. Wherever a large cluster of information came from the same document, that document is listed. The other elements are synthesized together, so that they can be presented in logical order.

You can contact Pam at pamelawoll@sbcglobal.net. The final page of this handout contains information about her self-study workbook, *The Power and Price of Survival: Understanding Resilience, Stress, and Trauma*, available for free download from her web site, <http://xrl.us/humanpriorities>

Thought Bites

A few questions:

Traditional question: "What's wrong with you?"

Trauma-informed question: "What happened to you?"

Even more important question: "What's right with you?"

A few good quotes:

"All abuse is the abuse of power."

"An ounce of choice is worth a pound of cure."

"If people don't feel safe here, nothing else is going to happen."

"...Some of the thorniest problems in health and human services today may be the result of undiagnosed trauma among staff and clients. Often, if the problem is named correctly, solutions emerge."

Random statistics about women and trauma:

From many sources

Trauma and addiction in women:

- Women who experience violence in childhood are 3-4 times more likely to be raped
- Women who experience childhood incest, are twice as likely to be victims of domestic violence
- 75% of women in addiction treatment report having been sexually abused
- Nearly 90% of alcoholic women were sexually abused as children or suffered severe violence from a parent
- 55-99% of women with substance use disorders report having been victimized at some point
- 30-57% of women with addictions meet PTSD criteria (the rate for women is 2-3 times higher than that for men)

Women in general:

- 67% of abused kids are less than 1 year old, and 80% less than 3 years old
- One in six women will be sexually assaulted in her lifetime
- Adolescents ages 14-17 are by far the most likely to be sexually victimized
- Women and girls are more likely to be hurt by people know intimately
- Half of women experience a traumatic event, slightly less than men
- 1/3 of women experience sexual assault
- For an adolescent girl, her greatest risk of harm comes from a person she loves
- 83% of 8th-11th grade girls have been harassed at school, 38% by a teacher or another employee
- 20-25% of college women are victims of rape or attempted rape
- Girls ages 16-19 are four times more likely than women of other ages to be raped, attempted rape, or sexual assault
- Women are more than twice as likely as men (10% as opposed to 4%) to develop PTSD (possibly because sexual assault is more likely to cause PTSD), and more likely to blame themselves for traumatic experiences

Women and girls in the criminal justice system:

- 94% of women who are incarcerated have been the victim of at least one violent act
- 84% of female juvenile detainees have experienced trauma, and 18% meet the diagnostic criteria for PTSD
- 80% of women in corrections have experienced physical and sexual abuse
- 8 of 10 female offenders with mental illness been physically or sexually abused
- 75% of juvenile girls whom the court has judged delinquent have been sexually abused (one study has 92%)
- Risk factors for delinquency in girls include sexual abuse, maltreatment, early puberty onset, and intense mother daughter conflict
- Girls who have been sexually assaulted are 5 times more likely to commit delinquent acts
- Girls are the fastest growing population in the juvenile justice system, and a high percentage have histories of trauma and violence
- Incarcerated girls are 50% more likely to have PTSD than boys, and more likely to have experienced sexual abuse and victimization by the family, and to have run away from home to escape violence
- 70-90% of incarcerated girls have experienced sexual, physical, or emotional abuse

Women with mental health issues:

- 1 in 4 adolescent girls shows symptoms of depression—50% more than boys—and 1 in 10 has severe depressive symptoms. Abused girls have twice the number of poor mental health symptoms
- Schizophrenic and psychotic symptoms are strongly related to childhood abuse and neglect
- Among battered women, 54-84% have PTSD, 63-75% have depressive disorders, and 38-75% have anxiety disorders
- More than half of women seen in mental health settings have or are experiencing intimate partner violence
- 81% of women with bipolar disorder and 90% of women with dissociative identity disorder were abused as children
- 50-70% of women hospitalized for psychiatric conditions, 70% of women in emergency rooms, and 40-60% of psychiatric outpatients report physical or sexual abuse
- 97% of homeless women with mental illnesses have suffered severe abuse, 87% both as children and as adults

Women who experience intimate partner violence:

- More than 1.4 million domestic violence crisis calls are received each year
- More than 1000 women are murdered each year by their partner
- Women who are abused in childhood are 2-4 times as likely to be abused as adults
- Boys who experience or witness violence are a thousand times as likely to commit violence

Women in the military:

- Many studies have indicated that women are more likely to develop PTSD after combat, but some have shown it's about the same. Many studies indicate that most of women's post-deployment stress effects are tied to or exacerbated by military sexual trauma
- For women in the military, their greatest risk of harm comes from their fellow service member
- Female veterans are 9 times more likely to have PTSD if they have experienced military sexual trauma, 7 times more likely if they have a history of childhood sexual assault, and 5 times more likely if they have a history of sexual assault in civilian adult life

Women in other demographic categories:

- More than 40% of women on welfare were sexually abused as children
- 75% of refugees and 80% of international war casualties are women and children
- American Indians are twice as likely to experience sexual assault crimes
- 1 in 3 Indian women report having been raped
- 37.3% of women with disabilities have experienced violent abuse, many by personal assistants, compared with 15.4% of women without disabilities

Trauma and primary care:

- In one study, including trauma assessment in comprehensive medical evaluation led to 35% reduction in doctors' office visits in the next year, 11% reduction in emergency room visits, and 3% reduction in hospitalizations
- Only 23% of doctors, nurses, physicians' assistants, and medical assistants believe they have strategies that could help domestic abuse survivors
- One 2008 study shows that the cost of violence and abuse represents 17 to 37.5% of the total health care dollar
- Trauma survivors undergo fewer preventive healthcare interventions, in part due to secondary victimization
- Current healthcare education includes only 2 hours on trauma for medicine and dentistry, and 6 hours on trauma for nursing, but those focus primarily on mandated reporting

Post-trauma Responses

Stages of recovery (Judith Herman, from *Trauma and Recovery*):

- Establishing safety
 - Securing safety
 - Stabilizing symptoms
 - Fostering self-care
- Remembrance and mourning
 - Reconstructing the trauma
 - Transforming traumatic memory
- Reconnection
 - Reconciliation with self

- Resolving the trauma

Women's responses to trauma:

Women are more likely to develop PTSD if:

- They have a past mental health problem
- The trauma is very severe or life-threatening
- They have been sexually assaulted
- They were injured in the event
- They had more severe reactions at the time
- They experience other stressful events afterwards
- They do not have good social support

Women are more likely to be jumpy, have trouble feeling emotions, and avoid things that remind them of the trauma.

Domestic violence is disruptive to work schedules, retention, and advancement, and women who don't work are more likely to experience domestic violence

Sexual harassment is linked to anxiety, nausea, headache, high blood pressure, sleeplessness, and ulcers

Women take longer to recover and are four times more likely to have long-lasting PTSD. Women with PTSD are more likely to be depressed and anxious, and men more likely to have anger and turn to alcohol or drugs. Both may have physical health problems following trauma.

Women are more likely to seek treatment, and respond as well as men or better, and are more comfortable sharing feelings and personal information.

Alcohol and other drugs:

- May provide temporary balance for the chemicals disrupted by trauma
- May provide relief for acute or chronic pain related to the trauma
- Serve as self-medication for the pain of traumatic reactions
- May dull traumatic memories
- May provide stimulation to people numbed out by trauma
- Tend to complicate recovery from trauma—and vice-versa

Complex Trauma (developmental trauma)

- Often results from combination of abuse and neglect in childhood
- Risk factors include the complexity of traumatic stressors, the chronicity of exposure to trauma, repetition of traumatic experiences, having multiple perpetrators
- Complexity rises with the intimacy of the traumatic act (e.g., sexual abuse) and of the perpetrator (e.g., a relative or close friend of the family)
- If the child tells the family about the abuse and is ignored, punished, or subjected to escalated abuse, there is greater chance of complex trauma
- Complex trauma often includes unhealthy attachment patterns
- In complex trauma there is most often a loss of trust, and loss of a sense of self
- Complex trauma often includes a loss of the ability to regulate emotions and stress reactions
- Hypersexuality is often a part of complex trauma
- In people with complex trauma, dissociation can lead to big trouble

Tension reduction behaviors:

- Helpful
 - Distraction, self-soothing, positive stuff
- Harmful
 - Yelling, cutting, risk taking, self-harm, violence, compulsivity
- Pleasure just to feel “less bad”
- Sexual abuse ↑ → TRBs and IDU

Strength-based Approaches

Resilience includes:

Inside Resources:

- Courage
- Values
- Beliefs
- Etc.

Other Strengths:

- Inherited
- Learned
- Chosen

Skills:

- Natural talents
- Learned/practiced skills

Outside Resources:

- People
- Information
- Organizations
- Nature
- Etc.

**The more we exercise our resilience, the more strengths, skills, and resources we have.
Resilience feeds itself.**

Destigmatizing post-trauma responses:

- Call them responses instead of disorders
- Call them “adaptations” or “effects” instead of symptoms
- Teach the basic biology of resilience, trauma, and post-trauma reactions, as a way of normalizing post-trauma effects and empowering women.

Stabilization

Focus on safety first

- Normalize the post-trauma reactions
- Negotiate conditions of treatment
- Teach her to regulate stress responses and emotions
- Give her tools to help her practice her new regulation skills
- Encourage her to use self-regulation skills to keep a safe pace in disclosure of her story
- Talk to the trauma—and the resilience
- Monitor medications for side effects, interactions, and lack of effectiveness
- Help her create safety at home, and in her community

Build trust

- Women who have been traumatized have strong intuitive “radar”
- Respect their defenses, and don’t take these defenses away before they have the strength to protect themselves in more healthy ways.
- Set effective boundaries and help women learn to set and maintain boundaries
- Know that she may test you, and that your job is to pass the test
- Understand that you will make mistakes
- Focus on connection
- Be authentic
- Navigate the emotions you feel as a result of exposure to traumatic material, through training, supervision, technical assistance, peer support, and self-care

Promote empowerment:

- Involve consumers in meaningful ways in the design and delivery of services
- Be a teacher, so your client can learn about the nature of trauma and understand that she doesn’t need to be ashamed
- Answer the big question (“am I crazy”) with a resounding “no!”
- Triage challenges and address the ones with the greatest risk first
- Collaborate with women in the choice of services, etc.
- Build skills for self-regulation and emotion modulation
- Talk to the woman’s strengths
- Point to her resources
- Embody hope
- Foster her vision of what her life will be when she is substance free

Trauma-informed Care

Triggers for trauma in treatment settings include:

- Powerlessness, lack of control
- Use or threat of physical force
- Locked room or space
- Handcuffs, shackles, other restraints
- Lack of privacy
- Interacting with authority figures
- Removal of clothing, e.g., in searches, medical exams
- Pat downs
- Being watched (suicide watch)
- Loud noises

- Fear based on lack of information
- Darkness
- Intrusive or personal questions
- Seclusion and restraint:

To avoid crises, assess and build services to shore up potential triggers (e.g., financial challenges, reunification with kids)

Ways of handling situations that traditionally would have resulted in seclusion and restraint:

- Making alternative provisions
- Making provisions for menstruation
- Providing a clock, to reduce the sense of helplessness
- Using staff who are the opposite gender from perpetrator
- In preparation, getting information from women on their triggers, what helps deescalate them, and preferences for restraint and medications in the event of a crisis

Provisions for environmental safety:

- Well-lit spaces
- Security systems
- Giving women the ability to lock their doors
- Posting of their rights in understandable terms
- Culturally familiar decorations
- Child-friendly spaces

Making the emotional environment safer:

- Consistent, predictable, respectful, reasonable responses
- Asking what does and doesn't work for them
- Clear about how their information will be used
- Opportunities for their own cultural and spiritual rituals

Giving women control and choice:

- Helping them stay well informed about all aspects of their treatment
- Giving them opportunities for input
- Giving them control over spaces and their belongings
- Providing clear boundaries and advance notice on space checks
- Giving them opportunities for input into service goals, design, delivery, and evaluation
- Providing interventions that respect their culture
- Respecting and protecting their basic human rights and freedoms
- Forging collaborative relationships with providers

Core principles of a trauma-informed system of care (from the work of Maxine Harris and Roger Fallot, Community Connections): Safety, trustworthiness, choice, collaboration, empowerment

- Involve all aspects of activities, setting, relationships, and organizational atmosphere
- Involve all groups
- Make trauma-informed change a new routine, a new way of thinking and acting
- Thinking differently leads to changes, and reinforces the success and viability of the change

Traditional human service paradigm:

- Each system has a separate view of the individual and interprets problems as individual problems, synonymous with symptoms.
- The system either attributes too much or too little responsibility to the individual

Trauma-informed paradigm

- Integrated, whole-person view of the person and challenges
- Contextual, relational view of person and challenges and solutions
- Symptoms are seen primarily as attempts to cope and survive, as solutions
- Responsibility is allocated appropriately
- Primary goals of services are growth, empowerment, resilience, life skill development
- Prevention-driven priorities
- Time limits are driven by individual needs
- Each survivor has a unique and valuable perspective
- Empathic relationships are cultivated, with the understanding that these relationships are necessary to draw out the survivor's voice
- Safety must be guaranteed, and trust is allowed to build over time
- There is appropriate collaboration

Service-level changes in:

- Procedures and settings
- Formal service policies
- Screening, assessment, planning, services

Systems/administrative changes:

- Support for program-wide trauma-informed culture
- Training and education
- Trauma-informed human resources practices (e.g., hiring or identifying trauma champions, including trauma content in interviews, trauma-related activities in performance reviews)

Review service procedures and settings

- Identify formal and informal activities, settings, and sequence of events
- Ask key questions about each activity and setting
- Prioritize goals for change
- Identify objectives and responsible individuals

Assess trustworthiness, clarity, consistency, and boundaries

- Do organizational practices make tasks clear, ensure consistency, maintain boundaries (especially interpersonal boundaries)?
- How can services be modified to ensure that tasks and boundaries are established and maintained clearly, consistently and appropriately?

Assess empowerment, strength recognition and skill building

- Do practices prioritize empowerment, strength recognition and skill building?
- How can practices be modified to ensure that these experiences maximized?

From Prescott, defining the role of consumer-survivors in trauma-informed systems

Creating an atmosphere for consumer involvement:

- Plan enough time for cohesiveness, overcoming fears, getting over power differential, reflecting back what they say
- Hold meetings in neutral places, without the power differential, in places that are convenient and safe (particularly in locked settings)

- Adapt physical spaces so there are no blocked entries or exits, no overcrowding, no staff members sitting behind the consumers (particularly if they are women), and ask former service recipients to set up the room

Document the change process from the beginning, including strategies, barriers, lessons, and new approaches, using multimedia to bring to people who can't attend

From *Trauma Services Implementation Toolkit for State Mental Health Agencies*, reported in the National Center for Trauma-Informed Care 2008 update, Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services. **Twelve criteria for building a Trauma-informed Mental Health service system:**

1. Designated trauma function and focus in the department
2. State trauma policy or position paper
3. Workforce recruitment, hiring, retention
4. Workforce orientation, training, support, competencies, job standards
5. CSR (consumer/survivor/recovering person) involvement and trauma informed rights
6. Financing criteria and mechanisms for development of systems and implementation of evidence-based and promising practices and treatment models/services
7. Clinical practice guidelines
8. Policies, procedures, rules, regulations, standards
9. Needs assessment, evaluation, research on prevalence and impacts, assessment of satisfaction, service use and needs, monitoring and adjustment of trauma-informed and trauma-specific service approaches
10. Universal trauma screening and assessment
11. Trauma-informed services and service systems
12. Trauma-specific services, including evidence-based and promising practices and treatment models/services

Services for Women with Co-occurring Disorders

From *Creating Trauma Services for Women with Co-occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study* (SAMHSA, 2003)

Each site offers a core set of services:

- Outreach and engagement
- Screening and assessment
- Treatment activities
- Parenting skills
- Resource coordination and advocacy
- Trauma-specific services
- Crisis intervention
- Peer-run services

Characteristics of trauma-informed services:

- Infused with knowledge of the roles of violence and victimization
- Designed to minimize the possibility of retraumatization
- Hospitable and engaging

- Facilitates recovery
- Operates on empowerment model
- Respects choices and control over recovery
- Based on relational collaboration between the woman and the service provider that minimizes their power imbalance and sets goals that are mutual and collaborative
- Emphasizes women's strengths

The woman:

- Has her experiences and choices validated
- Builds on existing strengths, to feel stronger
- Understands herself and others
- Increases her self worth, competence, ability to act toward goals
- Becomes engaged with others
- Expands her resources and support networks
- Understands her experience within the larger societal context
- Can become an advocate for herself and others on meaningful things

Principles:

- Identify and recognize trauma, and respect its management as a central concern
- See symptoms as adaptations to manage
- View this adaptive behavior as a strength and reframe it as positive coping in the past, while she learns alternative responses for the present
- Understand triggers, what women need when they're triggered, and the creation of safe spaces to manage symptoms
- Violence, trauma, and recovery take place in relationships, and can be healed in empowering relationships
- Violence and trauma shape her belief systems, feelings, self perceptions, and relationships
- Services must validate her feelings, reframe experiences in detailed ways, involve her in making choices about options, convey concern and caring, respect boundaries, provide hope for change
- Meet her where she is with readiness assessments, pacing, and patience

Intimate Partner Violence

A World Health Organization study of intimate partner violence published in Lancet in 2008 found that physical and sexual violence ranged from 15% to 71% across countries, associated with significantly more reports of poor physical health, pain, difficulty with activities of daily living, memory loss, dizziness, vaginal discharge, and emotional distress. Strongest association was between intimate partner violence and suicide attempts. (From "Intimate partner violence and women's physical and mental health in the World Health Organization multi-country study on women's health and domestic violence: An observational study." Lancet, 371, 1165.)

Herman describes "coercive control" as a major source of complex trauma.

From *Addressing Domestic Violence in Substance Abuse Treatment for Women* (Illinois Department of Human Services)

Commonalities: Women with substance use disorders and women who are undergoing domestic violence may experience:

- Isolation, shame, guilt

- Bizarre or dysfunctional-seeming behaviors
- Traumatization
- Initial denial of problem
- Loss of support systems
- Fear of loss of children if they admit it
- Low ego strengths
- Magical thinking
- Impairment of ability to make logical decisions
- Involvement in the criminal justice system (as victim or perpetrator)
- Seeking services only in crisis
- Several returns to the substance or abusive relationship, before lasting change takes place

Tips for screening:

- Don't use terms that label or judge the behavior
- Ask her how you can best be of help
- Understand that she might not feel safe disclosing
- Emphasize that the battering isn't her fault
- Educate her about domestic violence and substance use disorders, to reduce the stigma
- Proceed sequentially, starting with the least sensitive and progressing to the most sensitive topics, using the least sensitive for relationship and trust building
- Be careful about criticizing the partner
- Avoid labeling survival strategies as codependent
- Get factual information, asking her to clarify vague response
- Don't discount her evaluation of her safety; she's the expert in that

Screening continues throughout interactions. Listen for subtle disclosure on misuse of power and control, not just physical abuse. Questions that might lead to formal screening:

- What happens when you argue?
- How safe do you feel with your partner?
- How safe do you feel when you leave there?
- What is one situation where there was yelling and screaming?
- What is one situation when things were destroyed?
- What is one situation where your partner pushed, slapped, or hit you?
- How does your partner show respect?
- How does your partner try to control your alcohol and drug use?
- What does your partner do that sabotages your efforts at sobriety?

Observe and note:

- Bruises, other untreated physical injuries
- Inconsistencies, evasiveness
- Frequently missed appointments
- Partner waiting for her during sessions
- Reports that her partner isolates her, prevents from counseling or support groups, threatens her, or forces to do things
- Evidence or reports of child abuse
- Reports of jealousy
- Statements that start with "my partner won't let me"

In the intake interview:

- Convey that the counselor understands abuse and trauma
- Explain how your program can help
- Determine if she is in crisis about ongoing abuse or recent trauma that needs attention

- Get the information necessary for the preliminary treatment plan, but hold off on probing until she's in therapy
- Don't force separation from children during the interview, and particularly don't have the children led away by someone the same gender as the perpetrator

Referral:

- Know your local domestic violence (DV) providers well
- Assure her it's not her fault, that she doesn't deserve it
- Encourage her to consider a shelter or provider who does DV
- Stress the value and connectedness of safety and sobriety
- See if there's anything about treatment participation that puts her at risk, and tailor the level of care accordingly
- Coordinate your services with those of a DV advocate, explaining confidentiality regulations and ASAM criteria
- Ask the DV advocate about legal remedies
- Have joint staffings and collaborative case management
- Provide a united effort with other systems, e.g., DCFS
- Coordinate discharge planning, especially from residential treatment

Intervention:

- Maintain safety and sobriety as top priorities, and include her in relapse prevention plans
- Understand that she may use substances to cope or be coerced into using them
- Her safety may be at risk from her using partner if she gets sober
- The most dangerous time for her is when she leaves the violent situation
- It may be unsafe for her to leave, even if her relationship is a primary trigger for relapse or post-trauma reactions
- Understand that she's choosing when it's safe for her and children to leave, and that may be never
- Women make average of 8 attempts before they're successful in leaving the abusive home
- Disclosure, contemplation and preparation (safety planning) are key elements
- Discuss the dilemmas that these issues create
- Don't do couple or family counseling or provide any information to the partner, for fear of punishment
- Understand that Domestic violence is not caused by the substance use disorder, and is not a symptom of it, but is about power and control
- Avoid implying that there's something wrong with her, or that she caused it
- Avoid words like "codependence," "enabling," and "powerlessness"
- Don't use confrontational techniques
- Be cautious in recommending 12-step groups, and help her translate their terms and concepts and supplement them if she chooses one
- Use gender-specific treatment and support groups
- Take self-sufficiency and childcare into account
- Use harm-reduction techniques and create a trauma-sensitive environment
- Understand and facilitate her expression of anger, help her see it as sign of healing, and balance her need to release her anger with the needs of other victims and survivors
- Understand that treatment may take longer than the norm
- Find less harmful but safer and sober ways to replace benefit of substances (e.g., they made her feel more powerful and sexy, less afraid of being alone)
- Use gender-specific methods of empowerment and self-discovery, using language focusing on empowerment
- Focus on strength and healthy decision-making (including skills for problem solving)

- If she needs different but integrated or coordinated services, try using collocated services and substance use disorder treatment that includes DV education by a DV advocate
- Make safety and substance use disorders the top priorities
- Use consultation and review to keep staff effective

Other considerations:

- If she's a mother, suspend your "no contact" rules with children, to allay her fears and avoid child welfare charges
- Let her meet with counsel, advocate or District Attorney for orders of protection, custody and support, and to appear at hearings
- With her consent, tell all staff about any orders of protection, and keep a copy in a confidential place on site
- Women at higher risk for violence when they are pregnant or post-partum

Investigate questions like

- Will she enter treatment with these conflicting demands?
- Which needs and demands take priority?
- Will acute dangers propel toward or away from treatment?
- Is readiness to change a single issue or a series of independent ones?
- Does readiness to change in different areas affect her entry in different types of substance use disorder treatment?

For confidentiality

- Use subtle and effective documentation to protect her information from discovery by harmful people
- Advise her of any potential consequences from her consent for release of information
- Require that she hold confidential any information from other clients

Digest of key points from Larry Bennett's and Patricia Bland's "Substance Abuse and Intimate Partner Violence" article from *Applied Research Forum* (May, 2008)

The Connection

The co-occurrence of substance use disorders and intimate partner violence runs between 25% and 50%. However, there is a connection between these conditions only in a sub-group of batterers and victims. A diagnosis of a substance use disorder is a better predictor of intimate partner violence than the quantity or frequency of use.

The choice to batter often precedes drinking and drugging. In some men alcohol use impairs their ability to judge social cues (e.g., partner's motives), react appropriately, and maintain attention. In general, intimate partner violence by men using illegal substances is more severe than by those using alcohol.

Growing up in a household with intimate partner violence is more predictive of developing a substance use disorder than having an alcoholic parent. Both childhood trauma and intimate partner violence increase the risk of substance use disorders, and vice versa.

Effects of Substance Use on Potential Victims

Substance misuse impairs her judgment, increases financial dependence, exposes her to violent men with substance-related issues, makes it harder for her to defend herself. She may be forced to use alcohol and drugs as mechanism for control, and her recovery may be sabotaged.

Her own substance misuse may lead to her stay in the relationship or keep her from protecting herself, but it doesn't cause her victimization. She may or may not know how to compensate for his drunkenness and stay safe, or she may have increased fear when he is drunk and allow his domination.

A woman may choose not to seek help because she fears arrest, deportation, or reports to child welfare authorities. Her compulsion and withdrawal may make it harder for her to get help for the domestic violence, or may make it harder for her to be believed. If she does make progress in escaping the situation, the stress of leaving him and becoming safe may lead to relapse.

Service Provision

Screening for both substance use disorders and intimate partner violence should take place in health care (primary care and mental health), child welfare, and public aid, but must be followed by engagement and referral to appropriate services.

Services for women should include at least outreach, screening and assessment, treatment, parental support, advocacy, trauma-specific services, crisis intervention, peer-run services. Overdose and suicide risk factors require immediate intervention. Behaviors resulting from this experience (e.g., self-harm, cutting, overdose, threats of or attempts at suicide) may make group living harder. Service networks and coordinated community responses are essential.

Couples therapy is contraindicated where intimate partner violence is a factor. Couples therapy may give the message that the violence is a "couple behavior," it may require that she lie in order to protect herself, or it may reveal things that anger her partner and bring retribution. In addition, couples counselors may not have training in intimate partner violence.

Half of the men referred to batterer intervention programs do not complete them, even those who are court ordered to attend. Motivational Intervention and other engagement and readiness-to-change strategies are indicated, especially if they are integrated throughout the program.

Cognitive behavioral group therapy can be effective for batterers on both the domestic violence and the substance use disorders, and integrated treatment is better for engagement, retention, and reduction of rearrests

Suggestions from the New England School of Addiction Studies

Provide screening for:

- Current safety
- History of childhood physical and sexual abuse
- History of adult domestic violence and sexual assault
- History of emotional abuse in childhood and adulthood
- Current symptoms

Word your questions in ways that are more acceptable, less stigmatizing, less labeling, more normalizing:

- Are you afraid of your partner or anyone else in your life?
- Has anyone threatened to harm you, your children, or your relatives?
- Have you been:
 - subjected to a verbal attack?
 - pushed, grabbed, slapped, hit, kicked, burned?
 - pressured to engage in sexual acts or to engage unsafely?
 - prevented from going places or seeing people?

Trauma-informed outreach and engagement

- Ask permission to speak with her
- Let her specify the type of privacy she needs
- Let her choose the level of self-disclosure she's ready for
- Give accurate information about services and their benefits
- Let her choose service providers

Trauma-informed case management

- Empower her as the expert on her own life
- Let her set her own goals and make decisions
- Help her recognize her strengths
- Emphasize skill-building
- Engage her in problem solving (and teach problem-solving skills)
- Include safety plans, crisis plans, and trauma-specific services

Service Provision for substance use disorders and intimate partner violence

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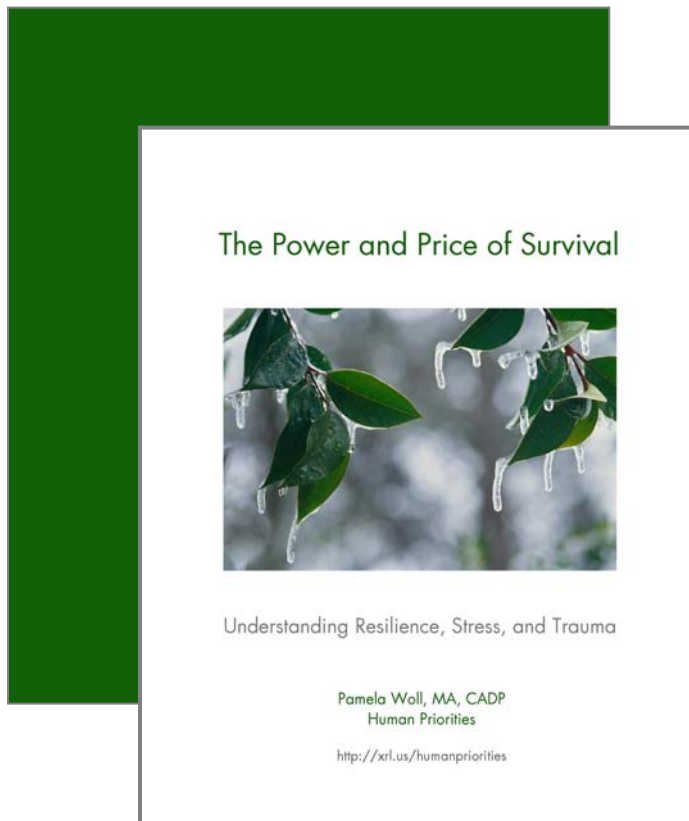
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The Power and Price of Survival

Understanding Resilience, Stress, and Trauma



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The Power and Price of Survival: Understanding Resilience, Stress, and Trauma is a 50-page workbook for general audiences, designed to make four things very clear:

1. We all have resilience—and ways of strengthening that resilience.
2. Post-trauma reactions really are signs of strength, rather than weakness.
3. The things that happen to memories after trauma are not signs of being "crazy" or "dwelling on the past." They make perfect sense, once we understand resilience, stress, and trauma.
4. There are many things we can do to bring the stress system back into balance.

You can download it for free from the Human Priorities web site, www.humanpriorities.com
The link for this workbook is: <http://sites.google.com/site/humanprioritiesorg/home/tools-for-growth-and-therapy/the-power-and-price-of-survival>