Societal Abuse, Oppression and Trauma

Societal abuse is a form of active abuse that refers to the disadvantages an individual or group experiences as a result of unjust social structures (Benbow, 2009). Societal abuse is a root cause of most other types of abuse – including domestic violence and sexual assault – and covers a wide range of issues (WHO/INPEA, 2002). Examples of societal abuse include sexism, racism, heterosexism and other forms of oppression that grant variable human worth to individuals based on misconceptions about race or ethnic culture, gender, sexual orientation, age, disability, socioeconomic background, recent immigration, military or other status.

Manifestations of societal abuse may range from overt or covert discrimination and lack of accommodations to inadequate funding for social services, lack of access to health care, inadequate social policies to protect against abuses, and negative images and stereotypes in the media (Schwartz-Kenney et. al, 2001). On both the individual and group level, societal abuse also tends to include the denial of victims’ pain and suffering, as well as blaming victims for abuses committed against them.

Societal abuse is perpetuated by society through its dominant culture and values, or by its tendency to accept abusive behavior toward marginalized groups (Schwartz-Kenney et. al, 2001). At its most extreme, societal abuse can take the form of human trafficking, forced dislocation and genocide. The trauma resulting from the societal abuse of oppressed groups can be passed from one generation to the next in the form of intergenerational grief and historical trauma.

The role of trauma in societal abuse/oppression

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

Marginalized groups tend to be disproportionately affected by poverty, homelessness and incarceration – not because they commit more crimes or have greater rates of pathology, but because discrimination often keeps them from getting the same benefits enjoyed by members of the dominant culture. For example:

• The U.S. Census Bureau reports that about 31.1 million people were poor in the year 2000, a poverty rate of 11.3 percent. However, the poverty rate for African-Americans, 22.1 percent, and Latinos, 21.2 percent, was about 3 times the rate for Caucasians at 7.5 percent (Davies, n.d.) The 1998-2000 poverty rate of people who reported they were...
American Indian or Alaska Native was 25.9 percent (Almanac of Policy Issues, 2001).

- Homelessness, like poverty, disproportionately affects members of minority groups (HUD, 2007). About 59 percent of the sheltered homeless population in 2007 and 55 percent of the population living in poverty were members of minority groups, compared with only 31 percent of the total U.S. population.

- With complex trauma and/or other psychiatric conditions, social marginalization and oppression often exacerbate or complicate symptoms (Briere & Spinazzola, 2009).

Internalized oppression occurs when people absorb society’s attitudes toward their group and direct those negative attitudes toward themselves:

- Internalized homophobia is associated with a lesbian/gay person’s devaluation of herself or himself, higher rates of concealing sexual orientation, greater depression and suicide risk, and other mental health and substance abuse problems (Green, 2007).

- Experiences related to racism and cultural oppression can alter a group’s collective identity, group-relational capabilities and societal worldview and can result in the emergence of projected self-hate onto other people in the group due to the horizontal hostility that cannot be expressed directly to the ones in power (Comas-Diaz, 2007).

One can think of internalized oppression as the internalized police officer that keeps individuals in their socially prescribed place (Roy, 2007).

Trauma can also be passed from one generation to the next.

Experts use the term intergenerational grief to refer to grief passed on from the generation experiencing the trauma to their children even though the next generation may not be aware of or have direct experience of the actual traumatic event. Unresolved grief can be passed on from parents to children to grandchildren and so on (AIFACS, n.d.).

Historical trauma refers to cumulative trauma – collective and compounding emotional and psychological wounding both over the life span and across generations. In other
words, it is trauma upon trauma that occurs in history to a specific group of people, causing emotional and mental wounding both during their lives and in the generations that follow (AIFACS, n.d.).

When discussing intergenerational grief or historical trauma, many people point to the loss of language and culture. Naomi Michalsen, Executive Director of Women In Safe Homes in Ketchikan, AK, says:

“I always went to these meetings, listening to the elders saying, ‘We’ve lost our language.’ Or, ‘Our language is going to be lost.’ And at first I couldn’t relate that to me. But now it makes sense, because I learned some of my own family history. It makes a lot of sense. It is me. And it does mean a lot to me. And it does apply to me. But I think my generation and maybe even younger kids don’t know how it applies to them” (Michalsen, 2007).

For many Alaska Native people, the historical trauma is recent, having occurred during the lifetime of people still living. A survivor shares:

“When I was 12 years old, I had to leave my village to continue on with my education. The trauma that I experienced was leaving my community. I’d never left my grandmother. I’d never separated from my parents. The cultural shock, the experience that I went through, and not having it explained to me why I am there in a big school with over 6,000 students. And I had to pay someone a nickel or a quarter or a dime to try to learn the language that I’m speaking to you today. We had no choice. Back then, it was not explained why I needed to go. Instead my parents were told, ‘If you do not allow your child to go to this school, you will be incarcerated. You will be in jail.’ And my parents took that and believed that. So I had to leave my community.”

Shirley Moses, Shelter Manager at the Alaska Native Women’s Coalition in Fairbanks, AK, often discusses the issue of historical trauma when presenting domestic violence or sexual assault education in the villages her agency serves. She says:

“When we bring up the historical trauma, the effects of domestic violence and sexual assault on children, and the way it affects them, we see an Aha! where a light goes on. And we see whole councils, the health providers and teachers and young parents, saying, ‘I didn’t realize that was happening to me.’ We’ve had 10 suicides this past year. It could be that these children have been abused. They see layers we have never processed – the suicides, the violent deaths, the changes in our lifestyle. And they start talking openly. They say, ‘This is not okay. This is wrong. We need to start looking at ways to strengthen and get healthier.’ And they might start by just saying they want safe homes” (Moses, 2010).

“We have many layers, and we need to talk about all of them,” says Naomi Michalsen. “Maybe we’re not ready to, but at the same time, we need to know they’re there. Intergenerational trauma definitely needs to be healed. We have to find out what our history is. Or try to find as much as we can” (Michalsen, 2007).
Barriers to service

People from marginalized groups often find it hard to access social services – especially if most of the staff represent the dominant culture and services are based on the values and customs and beliefs of the dominant group. Here are some of the barriers:

• *Discrimination by staff or other people against individuals who are receiving services.* Karen Foley, a behavioral health specialist and founder of Triple Play Connections in Seattle, says:

  “When it comes to homophobia, access issues are huge because people are so afraid of a woman loving a woman. For instance, having to share a room in a shelter with another woman becomes an issue for staff and for the people being served, whether that person has shown any inappropriate behavior or not. Racism is another huge issue that affects access to services, because we live in a society that responds to ‘normal’ based on what the provider’s view of normal is” (Foley, 2010).

• *Cultural barriers.* Different values and customs may make it difficult to access appropriate services. There may be language barriers, or customs that feel alien. Even the food served at a shelter or residential facility may be alien.

• *Conflicts over values.* A social service system with mostly Caucasian staff and dominated by Western ways of approaching issues may feel intimidating (Duran, 2006; Patterson-Sexson, 2010). Different providers may have different rules and priorities, some of which conflict – both with each other and with the culture of the person seeking services.

• *Trust issues.* People seeking help may not fully trust a provider from the dominant culture if they come from a different cultural background (Patterson-Sexson, 2010). There may be distrust between dominant and oppressed groups in the community as well. Someone who has experienced societal abuse or oppression may not trust providers because of bad experiences with authority figures such as teachers, previous social service providers or police who come from the dominant culture.

• *Fear of sanctions.* People with immigrant status may fear being deported if they lack documentation. An abusive partner or employer may have used this threat as a control tactic (Song & Thompson, 2005).

• *Fear of being discounted.* Allegations of discrimination or other forms of oppression are often dismissed by the larger society as “whining” or “playing the victim.” Other providers may have conveyed this attitude as well. Or providers may have blamed the individual for their problems based on stereotypes about the person’s race, culture, socioeconomic background or sexual orientation.

• *Fear of being judged.* An individual may have experienced being avoided or excluded because of misperceptions about race, culture, disabilities, socioeconomic background or
sexual orientation. Other providers may have displayed conscious or unconscious bias or behaved in ways that betrayed stereotyped thinking. A person may also have experienced cultural values or customs being pathologized or even declared morally wrong when they differ from those of the dominant culture.

- **Fear of losing children.** Studies show that children are more likely to be removed from people of color. In the past, children were removed from Native Alaskan or American Indian families and placed in boarding schools (Duran, 2006). ICWA, the Indian Child Welfare Act, was enacted in 1978 because of the disproportionate numbers of Native children being taken from their families and adopted into non-Native families (Holley, 2011). Fear of losing one’s children may also be active if lesbian/gay/bisexual/transsexual status, or disability status including substance use disorder or psychiatric illness is disclosed.
• **Fear of losing autonomous decision-making power.** Some people from marginalized groups may have experienced providers from the dominant culture trying to impose their own customs or values. Providers may also have difficulty trusting people who seek their help because of stereotypes and conscious or unconscious bias, and may create rules and restrictions based on this lack of trust (Leal-Covey, 2011).

Empowering people from socially oppressed groups

Here are some ways to empower people from marginalized groups.

• Cultural competence is important in developing trauma-informed services. Trauma may have different meanings in different cultures, and traumatic stress may be expressed differently within different cultural frameworks. Therefore, it is important for providers within a trauma-informed system to work towards developing cultural and linguistic 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).

• Recognize the impact of societal oppression on wellness. Personal and relational needs, though essential, are insufficient for the development of wellness. Without satisfaction of collective needs, personal wellness can exist in limited form only. People require “well enough” social and political conditions, free of economic exploitation and human rights abuses, to experience quality of life (Prilleltensky, et. al., 2007).

• Respect spiritual needs. Some advocates and other professionals are uncomfortable with issues of religion and spirituality. However, many persons from marginalized groups view adherence to spiritual practices as resilience against adversity (Comas-Diaz, 2007). Tia Holley notes how important it is to ask what kind of spiritual support would be helpful:

  “As a Native counselor at a Tribal treatment center who believes in spiritual diversity, I introduced alternative spiritual recovery options to participants in substance abuse treatment. I was surprised to find many of the Native participants in treatment had a strong Christian belief system. I learned to always ask about religious or spiritual belief preferences first rather than make assumptions. I found the 12 Steps helpful in many cases since they are drawn from many different belief systems from Atheist to Russian Orthodox, Christian, Buddhist and with the Great Spirit as a higher power” (Holley, 2011).

• Be aware of possible philosophical differences. For example, most “mainstream” psychological philosophies 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).
An Alaska Native Survivor Speaks

Our traditional ways of communal living did not condone domestic violence, sexual assault or child abuse. Alcohol and drugs were not part of Native life. Even today there are more Native people who never drink or do drugs than there are Native alcoholics and addicts.

Acculturation and forced assimilation of Western values onto Traditional ways of living have caused a rift in family and community systems. Indigenous women, children and men have been disproportionately victimized and criminalized. Native women continue to be victimized, often by non-Native perpetrators. Our prisons hold a disproportionately high number of Native men, women and youth.

Overly conforming to Western standardization of care in the behavioral health field can be a form of internalized oppression. It is not empowering and less than helpful to believe the only reliable “cure” for behavioral health problems in Alaska is one based on theories and best practices created from within a limited Western worldview.

Traditional healing methods and effective Native service providers are essential in our field and must be included at all levels of care. Here in Alaska we are growing our own behavioral health professionals through culturally inclusive education programs such as Rural Human Services and I ask that agencies support their students in this endeavor so we can have the best of both worlds.

It takes more than taking a class, reading a book or watching a video to become “culturally competent.” Effective service providers research historical and ongoing treatment disparities as well as introduce themselves to local Native Tribes and create a working relationship based on respect. A great place to start is by calling your local ICWA (Indian Child Welfare Act) worker, or Tribal Cultural Program.

Survivors share what helped them feel empowered:

One survivor shares: “Learning some of these stories about what my great-grandmother had to go through and then my grandmother. My great-grandmother was abandoned. She didn’t have her family or anybody left. My grandmother was abandoned by her mother because of drinking and all the issues. My grandmother left my mom when she was younger, and my mother was raised with my Grandpa until she was 13. And so when I was having all these difficulties with my daughter, I was just thinking, “Wow, you know, she’s 13 or 14 and nobody’s done this before in my family. It’s the first time.” When you think about where we learned our stuff, it’s from our parents. It’s at the boarding schools where the parents were all abused.
Some people had a great experience, but for my family, it wasn’t. So it was like a realization. I had this great feeling of sadness, because I hated my mom. In reality, she was a survivor. My grandmother was a survivor. And my great-grandmother. So I have even more love for them for surviving.”

Another survivor shares: “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 less judgmental, less critical. They have big elephant ears ready to listen. … I had to go back to my own Alaska Native values. I had to go back to my survival skills, because I fish and hunt with my children. I had to go back to those values and to think that I can survive. I can overcome. Because those activities – remaining active, building trust, building the process with children, building time with family – will help you recover. You will become a very strong individual, because I’ve become a very strong individual. I show it. I walk it. I talk it. I give it. It’s a light that we gain within ourselves when we start going through a healing process.”

Working with other providers

• Collaborate with indigenous providers, when available. Recognize and enlist the assistance of recognized helpers such as indigenous healers, elders or other leaders. Cultural ritualistic practices such as herbal cleansing, sweat lodges, pilgrimages, meditations and labyrinth walks are often useful in dealing with trauma and addressing low self-esteem (Comas-Diaz, 2007). Chemical dependency counselor/advocate Tia Holley shares:

  “I found Native victims were much more comfortable and followed through more with ongoing service when a Native Advocate who was knowledgeable of cultural issues and cultural and community resources was present from the start when I worked as the Native Sexual Assault Advocate for our local Tribal Agency under the Stop Violence Against Native Women’s grant” (Holley, 2011).

• Provide cross-training for providers on diversity issues. Get to know the cultures in your area, as well as the groups that address LGBT issues or disability issues, and invite people from these cultures or groups to provide training for staff.

• There is a need for system-wide advocacy by advocates and other providers. Practitioners need to understand the structural roots of oppression within our larger society and engage in social action to promote social justice at the societal level (WHO/INPEA, 2002).

• Encourage individuals to get involved in groups that work for change within the system. Because oppression can lead to feelings of powerless, many trauma victims from marginalized groups find healing and transformation in activism. Ideological understanding and political consciousness of oppression, in addition to social activism,
facilitates recovery and healing from discrimination and other forms of societal abuse (Comas-Diaz, 2007).

References


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


