MULTIPLE LAYERS OF TRAUMA

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

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

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

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

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

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

An individual may experience co-occurring psychiatric or other disabilities or experience a medical condition that impacts options. These issues may or may not be a direct result of trauma, but they often complicate efforts to address it.
When traumas accumulate over time, they may be associated with more severe and complex psychological reactions (Briere & Spinazzola, 2009; Brodland, 2010). Such experiences not only can produce long-term consequences themselves, but they are also risk factors for re-victimization in the future and for responding to later traumas with more extreme symptoms (Herman, 1997). Trauma may also be intensified by environmental variables, such as inadequate social support and stigma associated with certain traumas.

**Does interpersonal violence cause co-occurring issues?**

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

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

Depression, post-traumatic stress disorder, anxiety and panic disorder are common among people seeking services from domestic violence shelters (Warshaw et. al., 2003). However, some experts believe that many behaviors and responses seen as “symptoms” by service providers are directly related to traumatic experiences that can cause mental health, substance abuse and physical health concerns (NCTIC, n.d.). Survivors of sexual assault or domestic violence are also often misdiagnosed as having mental health or psychiatric disorders, because the symptoms of trauma can masquerade as mental illness, and mental health problems can be “situational,” brought on by domestic violence or sexual assault, and other traumas (Moses, 2010).

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

Interpersonal violence and poverty also are interwoven (Davies, n.d.). Domestic and sexual violence can push victims into a cycle of poverty. Experiencing interpersonal violence can lead to job loss, poor health, and homelessness. It is estimated that victims of intimate partner violence collectively lose almost 8 million days of paid work each year because of the violence perpetrated against them by current or former partners or dates (Cawthorne, 2008).
The Adverse Childhood Experiences (ACE) Study provides data linking adverse childhood experiences such as sexual abuse and witnessing domestic violence as factors contributing to psychiatric illness, substance abuse and other health problems (Felitti et al, 1998). However, the extent to which these and other issues make a person more vulnerable to interpersonal violence requires more study by feminist researchers.

It is important to emphasize that people who experience interpersonal violence neither “ask for” nor deserve violence or abuse – no matter what else is going on. The most important message you can give a person whose experience includes multiple abuse issues is, “This is NOT your fault.” This message is especially important if individuals were under the influence of alcohol or drugs, were experiencing psychiatric symptoms, or were coping with other co-occurring issues at the time an abuser took advantage of and hurt them.

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

Another layer of trauma: Societal abuse and oppression

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

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

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

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

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

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

**Barriers to service for people seeking help**

Very few programs provide comprehensive services for people impacted by multiple issues. Survivors of multi-abuse trauma are often invisible when in our programs, or are perceived as disruptive when co-occurring issues such as substance use or psychiatric symptoms become evident or unmanageable. Many times people with co-occurring or multiple abuse issues are missing from community programs altogether. Victims of domestic violence and survivors of sexual assault who struggle with multi-abuse trauma often need our services the most. Yet, having multiple issues makes it harder for a survivor to access appropriate services in a variety of ways:

- **Confusion over how to access services.** One study found that people with mental health concerns are often confused over how to access and use available services. The more severe the psychiatric disability, the greater the level of confusion (Rosenheck & Lam, 1997). This can be an issue for people who have other co-occurring issues as well.

- **Lack of self-advocacy skills.** Not knowing how to advocate for oneself can pose a significant problem for people coping with multiple issues (Obtinario, 2010).

- **Fragmented services.** For people who live in urban areas with many kinds of services, the system may be fragmented and they cannot receive everything they need from one provider (Akers et. al., 2007). An individual may need to go to one provider to access domestic violence services, another provider to obtain treatment for a substance use disorder, still another provider for mental health services, and several more providers to receive public assistance.

- **Hard-to-access or nonexistent services.** If someone lives in a rural or remote area, these same services may be extremely hard to access, or may not be available at all.

- **Lack of family-focused services.** Services for parents and children may be fragmented.
Funding streams, and program eligibility requirements for mental health centers and other services may limit participation to eligible adults or children, but not both. Services for adults and children may be provided in different locations. Programs or treatment settings may not allow adults to bring their children with them – e.g., emergency shelters or residential programs (Nicholson et al., 2001).

- **Conflicting expectations.** Each provider may have different rules, some of which conflict. For example, a substance abuse treatment program may require attendance at a group counseling session that extends until after the curfew at the domestic violence shelter where an individual is staying. A public assistance program may require applicants to be seeking employment, while some “half-way houses” may require the same individual to delay seeking employment until after completing other goals identified in treatment plans.

- **Inability to afford services.** People may be unable to afford some mental health or substance abuse treatment services if they do not have insurance, or if they have insurance that doesn’t cover services adequately (a problem for an increasing number of middle-class people as well as people living in poverty). Even if services such as domestic violence advocacy, sexual assault counseling or mental health services are offered free of charge by advocates or other providers, some people may not be able to afford babysitting, accessible transportation, or (for people with disabilities) medical equipment or a personal attendant (Leal-Covey, 2011). A fragmented system makes services harder to access, particularly for someone who lacks accessible transportation.

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

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

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

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

Challenges for providers

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

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

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

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

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

• Personnel shortages. Limited budgets, geography and weather often mean staff and resources are stretched to the limit.
The desire for success stories. Both funding organizations and the public tend to want success stories, in which the success is evident in a form that is measurable. This can lead to the temptation for service providers to engage in “cherry-picking.” Because of the desire to show funders that one’s program is successful, a provider may either consciously or subconsciously pick participants deemed to have the best chance of succeeding, while screening out those who might “fail” or those who would take too long to succeed. This can work against survivors of multi-abuse trauma who are dealing with multiple issues that take longer to resolve.

Manipulation by abusers. Naive, inexperienced or inadequately trained staff may fail to fully understand tactics batterers use or underestimate their willingness to go to whatever lengths are necessary to maintain control of those they perceive as belonging to them. This serious mistake can leave providers vulnerable to manipulation by batterers and subject to collusion. Failure to identify risk undermines treatment efficacy and victim safety. It may also lead to increased liability.

Barriers to cooperation between providers. Cooperation between providers from a variety of disciplines is needed in order to address the multiple issues involved in multi-abuse trauma. Developing linkages or collaborating across these sectors is fraught with problems, and many barriers to cooperation exist. These include differing priorities, funding restrictions, lack of trust between providers with differing philosophies, and lack of cross-training in issues other than the issue addressed by a particular agency.

Consequences when co-occurring issues are not addressed

Advocates and other providers agree it is hard to meet higher-level needs such as emotional healing when basic needs such as food and housing are not met. When a multi-abuse trauma survivor’s issues are not adequately addressed, serious consequences may follow:

- Physical and medical problems can develop.

- Ability to maintain employment, housing, health insurance or child custody may be threatened by current or past substance use disorders or mental health problems (Akers et al., 2007). Societal attitudes tend to view substance use disorders and psychiatric symptoms as moral failings rather than as health problems. This can lead to isolation and shame, which may be compounded when domestic violence and/or sexual assault co-occur with these other issues.

- People with multiple issues may believe they have no other choice but to return to an abusive situation again and again, because they have nowhere else to go where they feel welcome or safe.

- Individuals may bounce in and out of the system, moving from one social service agency to another, resulting in a revolving door syndrome in which underlying problems
and issues are never adequately addressed (Akers et. al., 2007).

- Survivors may develop coping mechanisms such as substance abuse or eating disorders to deal with continuing trauma, or to self-medicate post-traumatic stress disorder stemming from interpersonal violence or abuse (Bland, 2007).

- Inability to access appropriate services makes it more likely that trauma of all kinds will continue, resulting in even more trauma.

- Ultimately, an individual may end up on the streets, homeless, or even incarcerated.

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

**Yet another layer: Trauma from the system**

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

- When social service fragmentation leads to people getting passed around to numerous providers, these individuals may be left with the feeling no one cares about them or wants to deal with their issues.

- Each provider may have their own theory about what causes human problems. If people who seek help are pressured to adopt these conflicting theories, they may become confused and angry.

- As people with multiple issues revolve around the system, they may acquire multiple labels. They then become defined by their labels rather than viewed as human beings, and are thus dehumanized by providers in the system as well as by their abuser.

- The experience of being labeled, dehumanized, and passed around the system re-traumatizes people with multiple issues, making it even more difficult for them to address their issues.

- For many survivors of trauma who have disabilities or psychiatric issues, systems of care perpetuate traumatic experiences through invasive, coercive or forced treatment that
causes or exacerbates feelings of threat, a lack of safety, violation, shame and powerlessness (NCTIC, n.d.).

• Intimate partner violence, substance abuse or dependence, and mental illness all may result in a person becoming homeless (NCH, 2006). Psychiatric symptoms and homelessness have become criminalized, and jails and prisons have become a dumping ground for warehousing people with mental health issues and people who are homeless (Treatment Advocacy Center, 2007).

• The tools a person uses to cope with trauma – such as substance abuse, commercial sex or running away from home (if under 18 years old) – are often pathologized or criminalized (Gilfus, 2002). An example of this would be an adolescent girl who runs away from home to escape incest and is forced into commercial sex or is incarcerated in a juvenile detention facility.

• The physical and psychological violence of commercial sex or sex trafficking, the constant verbal humiliation, the social indignity and contempt, can result in personality changes that have been described as complex posttraumatic stress disorder, particularly if the individual was forced into the sex trade (Herman 1997).

• People who become homeless find that homelessness itself is a traumatic experience. Individuals and families who are homeless are under constant stress, often unsure of where they will sleep tonight or where they will get their next meal (Barrow et. al., 2009).

• If people with multiple issues end up homeless or incarcerated, they may then suffer posttraumatic stress disorder from the homeless or incarceration experience (Wong, 2007). A person who has been incarcerated – especially if incarcerated more than once – may suffer from post-incarceration syndrome, a form of post-traumatic stress disorder stemming from the incarceration experience itself (Gorski, 2001).

• People experiencing multiple forms of abuse may actively hide what has happened to them, as well as their methods of coping. Thus, their experiences of multiple forms of abuse become invisible.

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

This response silences those who seek services, drives these issues underground and rewards those who can cover up best. The secrecy and invisibility lead to more juggling, more trauma, more shame and greater risk for future harm as survivors increasingly fear revealing who they really are and remain invisible, silent and afraid to ask for what they really need beyond what is most pressing. Survivors may want to please advocates rather than disappoint them. They may fear being judged, reported to authorities, kicked out, or labeled.
Additionally, some advocates may be afraid to ask survivors about indicators of substance use or other concerns, due to fear. This may be fear the advocate won’t know what to do, fear of how the individual seeking services will react, or fear the advocate will have to ask the individual to leave.

The resultant aura of invisibility maintains an uneasy status quo that can be shattered at any moment. Should a problem erupt, its exposure has the capacity to overwhelm a survivor’s ability to function – let alone experience safety, autonomy and justice. A punitive response could also lead to increased trauma, isolation and shame. Providers across disciplines have begun to agree that we all must broaden our focus to at least consider what other issues people may be facing when they come to us for services.

References


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


Minnesota Coalition for Battered Women. (1992). *Safety first: Battered women surviving violence when alcohol and drugs are involved*. St. Paul, MN.


[SAMHSA] Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. (1997). *Substance abuse treatment and domestic violence* (DHHS Publication no. [SMA] 97-


Slater, N. Graduate School of Psychology, Antioch University, Seattle, WA. Personal Communication with Patricia Bland, September, 1994.


