

# 1.1 Use of Language and Diverse Voices in the Tool Kit

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## Aim Of The Tool Kit

The aim of this tool kit is to actively engage readers in applying a feminist analysis to women's experiences of mental health, substance use and past and current experiences of violence. The tool kit contains a wide variety of voices that speak to these issues by drawing on a range of sources: the experience of providing services to women, theory, research, feminist activism and scholarship and, naturally, by the writers' own experiences of substance use, mental health problems and violence.

In producing this kit we have allowed these different voices to emerge, and we see them as a key strength in helping to provide a rich and diverse document. In gathering these contributions together, we have collected service providers' narratives, honouring oral tradition through the practice of interviewing women practitioners and using their analysis to inform this work. We have also asked women who have experience of violence and of using anti-violence services to write about what helped them and to ask their service provider supporters to provide a commentary on their experience of working with them. The stories of survivors are placed throughout the tool kit, and we hope that they will illustrate both the barriers that women with multiple issues face in reaching safety and accessing effective services as well as the importance of working from an integrated model of addressing violence, mental health and substance use. Contributors and reviewers of the kit have come from various professional backgrounds, including: research, advocacy, community organizing, Community-Based Victim Assistance, Stopping the Violence Counselling, Stopping The Violence Outreach and other service provision. It is our hope that you find the diverse perspectives and contexts contained in this kit helpful in assisting you to expand your knowledge and in providing new tools for your support work with women.

## Scope Of The Tool Kit

We are focusing on women who have survived violence and who are dealing with mental health and substance use issues because that is an area in which our membership<sup>1</sup> has asked us to provide resources. The scope of the kit does not allow us space to address the particular safety and support needs of all women with disabilities, including women with developmental disabilities. There is a section on working with women with FASD, which relates to women who have a brain-based disability. This is the only section that has a wider disability focus. There is a significant need for more information and tools on supporting women with disabilities who experience violence and this warrants its own manual, which we hope could be produced in the future.

...providing new tools for your support  
work with women.

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<sup>1</sup> The BCASVACP has been receiving requests for the development of a resource like this since 1999. In the spring of 2007, the BCASVACP surveyed STV counsellors, STV Outreach workers and Community-Based Victim Assistance workers about what material they wanted this tool kit to cover. The contents reflect the input we received from them and from our advisory committee.

We have provided some helpful resources on women with disabilities and violence in relationships in our resources section at the end of this kit. Another area that we have not been able to address adequately is violence against transgendered people. There are high rates of violence directed towards people who identify as trans (the impact of violence can be different and access to services more limited); however, these issues are beyond the scope of this kit to address<sup>2</sup>.

## Language Used In The Tool Kit

Language is a complex area in the fields of mental health, substance use and violence against women. It can be a site of struggle, particularly when trying to adequately describe personal experiences within wider contexts of power and resource inequality, such as gender inequality. Language shifts and evolves with changes in our values and ways of understanding these issues.

Feminists have argued that much of the language traditionally used in the mental health and substance use fields can be viewed as pathologizing women's responses to violence, trauma, poverty and inequality.

When we decided to write this document, we had to make some choices about our use of language. We wanted to find language that captured the considerable differences existing across personal experiences as well as the commonalities.

### Anti-Violence Language

We have chosen to use the terms "violence," "trauma" and "abuse" interchangeably in an attempt to address the breadth of violating experiences that women are subjected to. Violence includes physical, sexual and emotional abuse and financial exploitation in relationships with men and in same-sex/gender relationships; sexual assault and criminal harassment. Abuse includes historical experiences of child physical and sexual abuse and neglect. Trauma stems from all of these experiences, and includes the impact of colonialism, ableism, racism, heterosexism and other systemic oppressions that can hurt and violate women as much as an act of physical or sexual violence.

### Mental Health Language

The term "mental illness" is still very common in Canadian research and literature that describes mental and emotional experiences that are unusual or problematic. This term is situated very clearly in the medical approach to health. Many argue, however, that some conditions, particularly very common ones, could be seen as normal life experiences rather than illness. For example, severe low mood, typically described as depression, is a very common experience for people to have at some point in their lives, especially for women.

Also, many who are labelled as having mental illness or mental health problems do not describe their experiences in these ways, and instead create their own meaning and ways of describing their experiences to others and for themselves. One example of this is the movement of people who hear voices who have begun to radically challenge the dominant view of psychiatry that hearing voices is an unusual and negative experience that indicates a serious mental illness requiring medical intervention and medication. They argue that hearing voices is actually much more common than generally realized, particularly amongst people who have had intense experiences of some kind, including experiences of loss, violence or trauma.

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<sup>2</sup> Please see the Vancouver Coastal Health website for an excellent range of resources and links on transgender health: <http://www.vch.ca/transhealth/resources/library/index.html>. Please also see "Safety assessment and planning for people in abusive trans relationships" in *Aid to Safety Assessment and Planning (ASAP) Manual for Women Who Experience Violence in Their Relationships*, by the BC Institute Against Family Violence (2006). There is also a good leaflet containing information and resources produced by the BCASVACP accessible at [www.endingviolence.org](http://www.endingviolence.org).

The contributors to this kit do not subscribe to a medical model of understanding mental distress, so this tool kit will not use the term mental illness. Instead we use the terms "mental health problem" and "mental health issue," though of course this is still not a perfect solution.

The kit will use the term "consumer" or "survivor" when talking about women who are past or current users of the mental health systems. Consumer is a term that is situated within the mental health system and is currently adopted by many people who access that system, alongside the term survivor. The term survivor in this context means that the person is a survivor of their life experiences, their mental health difficulties or the mental health system itself.

### **Substance Use Language**

In writing this tool kit we recognise that there is a continuum of substance use and the line between "use" and "misuse" varies considerably. Because of this, and because of our aim to avoid making judgments about a women's substance use, we have chosen to use the terms "substance use" or "problematic substance use," rather than substance abuse. "Substances" include licit drugs: alcohol, tobacco, prescription drugs and solvents, and illicit drugs: marijuana, heroin, cocaine etc. Services for those with substance use problems are referred to as "substance use or addiction services."

## 1.2 Survivor's and Service Provider's Stories

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### A Survivor's Story<sup>1</sup>

A question prompted me to reach out and make that first phone call to a women's service. The question was about my rights regarding stalking by a past abuser that has lasted for the past 20+ years. I know that's a long time and some may ask why and my answer is.... Because I didn't know I could do anything about the situation without compromising my SAFETY and my standing in the community. It's not a thing that many people have the stomach for, and 20 years ago I was filled with fear, shame, hopelessness and last, but certainly not least, there were not a lot of resources available for me to access and those that did exist could not help me establish a plan that was going to help me stay safe through the process.

When I heard a friendly voice answer the phone at the local women's service, I felt my mouth go dry, my thoughts were scattered and my words sounded like gibberish, at least to me. When the voice on the other end of the line answered my question with an unequivocal YES, you do have a very good reason to call the police and make a complaint, I felt a balloon of hope rise in my chest and the first tears of healing rolled down my cheeks.

I am going to guess that it was the balloon of hope and the tears of relief that gave me the strength to reach out with the other hand and believe me when I say, I was not disappointed! I WAS VALIDATED! I can only say that for the first time in 20 years, I could stand up and say NOT ANYMORE...I AM TAKING BACK MY POWER.

When I called the RCMP and began the process of stopping up the leaking hole in my life, a new process began...healing. With the momentum I had gathered after making that first phone call, I called again, knowing that I was going to need some help with the logistics of court and the legal system and I was also going to need emotional support like never before! There they were all in one building.<sup>2</sup> Even today while writing this I get teary because I had, for lack of a better description, found what was sitting at the end of a rainbow...a nice shiny life toolbox to hold the new tools that were waiting to be used by me.

We began to work on one of the larger cornerstones of healing and that was MY SAFETY. They were pivotal in helping me create a SAFETY PLAN by providing me with information and options. Over the past 20+ years I did not feel safe and had spent too much time and energy being defensive rather than offensive...that never did work out very well for me. The SAFETY PLAN enabled me to redirect my energy towards other areas that would set into motion positive actions that would further maintain my SAFETY. Metamorphosis from victim/survivor to THRIVOR is evolving as I type.

The most difficult and challenging part of this new path was opening that first door. Yep, that was the door that, to my dismay, led to a hallway of other closed doors to rooms that needed to be opened and aired out or overhauled. Some rooms needed to be re-wired, while others needed some paint and then there were some that needed a complete makeover. However daunting the task(s) before me would be...I was now NOT ALONE. I had the beginnings of my HEALING FOUNDATION.

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<sup>1</sup> All survivors who shared their stories were given an honorarium to acknowledge their contribution.

<sup>2</sup> The service that this woman used has a transition house, Community-Based Victim Assistance Program and STV Counselling and Outreach program in one building.

My days are more tolerable and sometimes I even find myself feeling happy. I try not to let the days when a new "trigger" arises take me over like so many times before. I work with the tools given to me by my counsellor.

## **A Service Provider's Story**

The woman I am working with accessed my services because she no longer felt she could cope with the stress of being harassed by an ex-partner for numerous years. She was finding it difficult to attend work and was functioning with an intense level of hypervigilance and fear on a day-to-day basis. She expressed a desire to finally go to the RCMP with her experience of being harassed and I referred her to my CBVAP colleague to assist with that piece. The woman had also been accessing the mental health system over this period of time, yet she did not feel her work with this system was effective. As our work with her progressed, she expressed relief with our abilities in the anti-violence sector to tie together her experience of abuse, mental health assessment and current behaviour in response to ongoing trauma.

In responding to the complexities of this women's experience, I felt it necessary to create a framework of safety. There was a strong need for physical safety measures to be implemented, which the CBVAP worker was able to develop with the woman and the RCMP. In this particular case, the RCMP responded quickly and because of their positive working relationship with the CBVAP worker, played a role in validating the woman's experience. I feel the collaboration between the CBVAP worker, myself and the RCMP was a key component in her capacity to feel a sense of security. The other area of safety that was immediately worked with was her emotional safety. I worked with her to normalize the trauma-related responses she had been experiencing and to create some control over her own environment. We worked with both internal responses (anxiety, containment of emotions, stress-reduction tools) and external environment (the woman chose to quit a workplace that was causing her a great deal of stress, thus giving her time to focus on caring for herself).

Throughout my work with the woman, we redeveloped a relationship with the mental health professionals, as she, like many of the women I see, was on medication, which required ongoing consultation with a psychiatrist. My role in assisting the woman to navigate the mental health system was via encouraging her to advocate for herself with her psychiatrist regarding medication changes and her request for advocacy in order to obtain long-term disability. The woman also used her doctor as an advocate with the mental health system to ensure the treatment she was receiving was not causing further difficulties in relation to how she was feeling (e.g. three-month delays between psychiatrist appointments, ever-changing prescriptions of mood-altering medication).

At first I felt disheartened about the relationship the woman had with the mental health system over such a long period of time. How could a person with such obvious mental health difficulties, who had articulated the impact of her ongoing traumatic experience to the mental health professionals, be treated with such "bare bones" basic care? I still feel the mental health system fails to capture the link between trauma and mental health. However, through building connections with those working in the mental health system and liaising as a team to address women's issues, I feel we are beginning to capture the intersection of trauma and mental health and are better equipped to provide tangible supports to those seeking services.

The most significant theme from this story that has affected my work with women is how much I learned from the woman and her amazing resilience and courage to undergo transformation under great vulnerability.

This woman expressed her satisfaction that the CBVAP worker and I had consistently sent the message that she was in charge of her healing process. This experience has affirmed for me that as service providers, it is in our capacity to sit with women and humble ourselves in our knowledge of the human experience that we are most effective in supporting their journey of transformation.

# 1.3 Trauma, Mental Health and Substance Use Within an Anti-Oppression Perspective

BY ANGELA MACDOUGALL, TESSA PARKES,  
SARAH LEAVITT AND SUSAN ARMSTRONG

In this section we outline some key elements of a respectful, effective, anti-oppression approach to working with women who have experienced violence and who use substances or have mental health issues.

These elements include:

- Coming from a foundation of honest self-reflection
- Asking value-neutral questions and listening to the answers
- Examining and resisting societal beliefs about mental health and substance use; understanding oppressions such as racism, sexism, ableism, poverty, homophobia, transphobia, colonization, etc and how they relate to beliefs about mental health and substance use
- Maintaining an attitude of engaged neutrality when providing services
- Focusing on behaviours and context as opposed to labels and diagnoses

The approach that we describe here is simple and complicated at the same time, like much of the work that we do with women who have experienced violence. As you read through this section, you might find yourself thinking that it sounds very simple, and it really is: at its heart, this approach is simply about working with women in a respectful, open manner. However, at the same time, it is very complicated: it requires unlearning many beliefs that we have been taught, becoming aware of our own and societal attitudes that are often invisible, and being extremely self-aware. It is the kind of approach that is not just learned once and then used; it is a constant process of learning and refining.

Experience and research has taught us that survivors' lives improve in ways that most matter to them, i.e. being safer, happier and having healthy relationships, when they receive integrated services in which they can work on issues of violence, mental health and substance use with the same worker.<sup>1</sup> In one study, in terms of reduction of symptoms, the most significant improvement that women experienced through integrated services was a reduction of posttraumatic symptoms and drug use severity. Women who simply received increased services from a variety of practitioners (anti-violence, mental health and substance use) had *fewer positive outcomes* than the women who received integrated services. Women want spaces where they can talk about the totality of their experiences. For example, as a woman prepares to testify in court, she wants to be able to talk about her panic attacks and to strategize about how to manage them. This woman may also be concerned about how she will be able to show up for court without using, when she knows that her drug use is how she manages stressors in her life. These are all conversations we need to be able to have; it is our work. In every conversation we have with women, we are also cognizant of the impact of social location on her experiences of systems and simply being a woman in the world. Creating a safe and effective working relationship with a woman means supporting her in naming her experiences of societal oppression, acknowledging its impact and honouring the ways she maintains strength and dignity for herself.

<sup>1</sup> This was one of the significant outcomes from a five year study undertaken by SAMHSA, in which women who were survivors of multiple forms of violence and who had mental health and substance use issues as well as many societal barriers (poverty, illness, disability) received integrated counselling. For more information see [http://mentalhealth.samhsa.gov/nctic/sponsored\\_initiatives.asp](http://mentalhealth.samhsa.gov/nctic/sponsored_initiatives.asp)

## 1.3.1 Societal Beliefs About Women with Mental Health and Substance Use Issues

### Mental Health Issues

Crazy. Schizo. Mental. These terms conjure up such scary images. We might picture women who are out of control, violent, dangerous.

And technical terms might not be any less loaded. Highly dissociative. Dissociative identity disorder. Delusional. Borderline. What do these labels mean? What do women with these labels look like? Act like?

"Mental health issues" is a broad term: it can apply to a range of experiences and behaviours, and underlines the fact that mental health is more of a continuum, as opposed to there being a clear line between health and illness. Using this term can help us to think about what we see as a mental health issue and what we see as a "normal" response to trauma and to consider whether we may have our own mental health issues, even if we don't think of ourselves as crazy.

### Women and Mental Health

We believe that it is impossible for women to experience trauma without having some sort of mental health issue as a consequence. A woman who experiences violence may be depressed, anxious or angry for a period of time afterwards, or she may suffer for the rest of her life from intense flashbacks, chronically high levels of fear even in safe situations, or the belief that she is always being followed or watched. The impact of trauma on mental health cannot be predicted, and depends on the type of trauma, the age at which the trauma occurred, the relationship between the victim and the offender, body chemistry, past experiences, the level of support she received immediately following the trauma and her current level of support, and her use of legal or illegal drugs.

Feminists have fought against the psychiatrization of women for decades. It is not uncommon for doctors, psychiatrists, counsellors or other health care professionals to give a woman a psychiatric diagnosis if she is experiencing mental or emotional distress. Historically, many have not taken into account factors such as violence, trauma, poverty, oppression or other possible reasons for her struggle. Feminists and others have criticized this trend, and argue that many women have been labelled as mentally ill when in fact they are suffering from the results of trauma or oppressions such as sexism, racism and poverty.

It is also important to keep in mind that many women experience mental health issues that are not caused by trauma or oppression. These women may benefit from psychiatric diagnoses and medications. Women with existing mental health issues are more likely to be abused than other women, and abuse will exacerbate these issues.

**N**ineteenth century diagnoses of "hysteria" assumed that a uterus and ovaries somehow placed women at risk for "nervous" disorders. On this basis, it was argued that women were unfit to vote, be educated or otherwise participate equally in society (Ehrenreich and English 1978 in Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006).

As frontline anti-violence workers, we must remember that it is not our job to diagnose women. It is not part of our work of supporting women and helping them to be safe. And it is not our area of expertise. However, it is part of our job to know (if she wants to share this information) about a woman's existing diagnosis or

diagnoses. What diagnosis does she have? Who gave it to her? (For example, we know a woman who was diagnosed as paranoid schizophrenic by a police officer and this label has stuck with her for years.) What does she think of the diagnosis? What does it mean to her? Does it fit for her?

You can research her diagnosis to make sure you understand it and its possible implications. But it is crucial not to see the woman through her diagnosis. It is a label that she has been given, not the core of who she is. You need to focus on whether and how this diagnosis will affect your work with her (see section on Definitions of Main Mental Health Diagnoses for more information).

**R**eflective Questions. What is society's view of an ideal woman? How might this view affect a women's mental health? What fears arise when a woman with mental health issues has children (society's fears, the woman's fears, your fears as a worker)? How have these fears manifested themselves in attitudes towards women you have worked with?

## Discrimination, Prejudice And Mental Health

- One person in five in Canada will have a mental health problem during their lifetime: over 6 million people (BC Partners for Mental Health and Addictions Information 2006).
- Data collected in Manitoba and Quebec "shows that substantially more women than men received a diagnosis of a mental health problem and of an anxiety/depressive disorder and that more women than men received a psychotropic or an anti-anxiety drug or antidepressant" (Ad Hoc Working Group on Women, Mental Health, Mental Illness and Addictions 2006).
- Numerous studies have shown that there are strong and complex connections between women's experiences of violence and trauma and their level of mental health (Hiday, Swartz et al 1999; Jacobson and Richardson 1987).

Many of the problems that people with mental health issues face are directly caused by the impact of discrimination on their lives. For example, unemployment rates for people with mental health issues in Canada lie at between 70 and 90%, depending on the severity of a person's issues. Lack of decent employment and educational opportunities result in higher rates of poverty and a loss of socio-economic status, often long after symptoms of distress or illness have been treated or supported.

Increased likelihood of victimization is another risk for people with mental health issues: they are more likely to be a victim rather than a perpetrator of violence towards another (Hiday, Swartz et al 1999). Teplin et al (2005) found that violent crimes against people with mental health issues were, on average, 11.8 times higher: rape and attempted rape were 22.5 times higher and sexual assault was 15 times higher. This fact largely goes unrecognised. In fact, individuals with mental health issues are more likely to be treated badly by the police and criminal justice system than those without this additional vulnerability.

The personal costs of living with a mental health problem in a discriminatory society are huge. A 2001 Canadian study conducted with people diagnosed with schizophrenia found that social withdrawal had a much more substantial impact on their lives than the symptoms of their mental health problem (Schizophrenia

Society of Canada). Social withdrawal, and the consequent isolation this causes, leads to increased loneliness, alienation and feelings of rejection and emptiness. These experiences make recovery a lot more challenging. Many people also internalize the stigma associated with mental health problems and feel very negatively about themselves, developing low self-esteem and self-worth, and harbouring guilt and shame concerning their issues (CMHA 2007). They may feel under pressure to hide their issues, withdraw from personal, social and community structures and supports, and be reluctant to ask for help. This can lead to additional isolation and distress.

**A**s a society we have done much to alleviate major clinical symptoms of mental illness, but little to alleviate the symptoms of societal discrimination ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)).

### 1.3.2 Mothering and Mental Health

Historically, women with mental health needs, or mental disabilities, were forcibly sterilized under the banner of eugenics and pursuing genetic purity. While this practice is no longer viewed as acceptable, there are many subtle and not-so-subtle ways that women with mental health issues are encouraged not to have children. Reasons given for this discouragement are due to their presumed psychological fragility, presumed inability to provide a stable home environment, and fears about passing on mental illness to another generation (Hamid-Balma 2004). A UK survey of people who use mental health services reports that 48% of women, and 16% of men, believed that their parenting abilities had been unfairly questioned because of their service user status (Reid and Baker 1996).

**T**he day-to-day struggles of women with mental health concerns who are mothers, and the strengths they display in managing all the demands on them, are largely invisible (Morrow 2004).

Support workers with good intentions may suggest that a woman put her children in care or have a family member care for them in order to ease her responsibilities while she deals with a mental health issue. This can be dangerous for women in terms of their rights to custody afterwards. In divorce proceedings it is common for a woman's mental health condition to be used as grounds for giving custody of the children to the father (Judas 2004).

Research indicates that women with mental health concerns often place a high value on parenting and that a woman's ability to maintain a relationship with her children is often critical to her recovery (Morrow 2004). To mother successfully, some women with mental health issues require additional supports such as advance planning and Ulysses Agreements that can help her plan for the times when she is unable to care for her children (Morrow 2004; for more information see The Representation Agreement Act, Ulysses Agreements and Advance Directives).

This is a prime example of why it is important to consider women's behaviours, as opposed to diagnoses or labels, when helping them to address their mental health issues. Is the woman behaving in a way that threatens her children's safety? Or does she simply have a label that carries negative connotations with it? (More on behaviours later in this section).

In the public policy arena too, an interest in mothers in crisis is often absent, concealed by a public focus on the rights and safety of children (Morrow 2004). The study *A Motherhood Issue: Discourses on Mothering under Duress* (2002) examined three situations of mothering most likely to be scrutinised by the mental health and child welfare systems, and where mothers were most likely to lose their children to the state:

- Women who were using substances while pregnant or as mothers
- Women who are mothers and experiencing relationship violence, and
- Mothers with mental health issues.

See the end of this section for resources on parenting with mental health problems.

### 1.3.3 Substance Use Issues

As humans, we seek out pleasure, or relief from pain, as do other animals. We have the technology to do this in many different ways, including the use of legal and illegal substances. We often become dependent on the method that works best for us.

**D**rug addiction is not a disease but a way of adapting to desperately difficult situations. People cannot be “cured” of adaptive strategies unless better alternatives are available to them (Alexander 1990).

Although the use of mood-altering substances has been a feature of human societies for thousands of years, and many of us use a variety of them today, addiction is still considered by the majority to be caused by a moral deficiency or lack of willpower. The dominant attitude towards people who have addictions is that they can just stop their drug or alcohol use if they really wanted to. People who use substances are often viewed as unruly, out of control, aggressive, inconsiderate, selfish, irresponsible and involved with crime, based on the notion that “drugs are bad and so are the people that use them” (The Stella Project 2005). They are held responsible for their problems and blamed. However, substance use only became criminalized in the last century and many people can and do use substances in moderation with few problems.

Not all substances are equally harmful. Indeed, many factors affect the impact of a substance on a person and their life, including individual health status, levels of exposure, combinations of use and related risk behaviours (Poole and Dell 2005). Risk is therefore subjective and mostly related to factors beyond the substance itself. Licit substances, including psychotropic medications, also have significant effects that people who take them are not stigmatized or blamed for in the same way. An exception to this is the use of and withdrawal from benzodiazepines.

**L**ess than one third of Canadians seek help with mental health or substance use issues (Statistics Canada 2003). Prejudice and discrimination are known to affect treatment behaviour, from attendance at self help/therapy groups to taking medications, with evidence that even a person’s degree and speed of recovery is influenced by the negative attitudes held about them ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)).

## Women and Substance Use

Although there are commonalities between men and women when it comes to use and dependence upon substances, there are also many differences. Rates of use for different drugs, the biological impact of substances, the risk factors, the nature of substance use related issues, and recommended responses, are all different for women and men (CCSA 2007). In general, women are less involved with substances than men, a fact that has led to substance use/addiction services being focused, to a large extent, on male clients.

Women who use substances have traditionally been viewed as deviant and undesirable: "by taking substances they are no longer replicating the desired role of women in society" (The Stella Project 2005). This may be truer in cases where the substance use is quite visible and makes a woman's behaviour loud, erratic or otherwise unusual. However, in many cases substances actually tend to make women more subdued and withdrawn, thus more "normal," according to stereotypes of the ideal woman. In these cases, substance use may go unnoticed.

**Women who are heavy substance users rarely use a single substance (Poole and Dell 2005).**

The traditional approach to women who use substances has largely failed to make the connections between the use of substances and the reasons why women may use them. There is now evidence from women, practitioners and research that clearly describes the connections between women's use of substances and their experiences of violence, abuse and trauma and of dealing with wider challenges such as poverty, unemployment, discrimination, pressures of caring for children and dependent others, lack of work and educational opportunities, and low status in society. According to Poole (1997), substance use patterns are influenced by a partner's substance use, social isolation, stressful life events such as a death in the family, and the challenges of living in poverty. Other advocates concur that women's substance use patterns need to be understood in relation to a number of contextual issues such as high incidence of physical and/or sexual abuse as a child, sexual assault or relationship violence as an adult, lack of social support, low self-esteem, stigmatization, need for social services and child care, need for support and education around parenting, relationship counselling, coping skills training, and vocational and legal assistance (Kearney 1997 in Rutman et al 2000).

High rates of violence in relationships, mental health issues, sexual assault and historical child abuse and child sexual abuse are common experiences for women with problematic substance use, suggesting that many women deal with these stressors by using substances. This practice is sometimes described as self-medication. For some women the substance use may help them to cope with recurrent flashbacks or triggers in daily life that remind them of the trauma and result in overwhelming emotional responses. Women who experience violence in relationships are also much more likely to misuse prescription drugs, alcohol and illegal substances than women who are not in violent relationships (The Stella Project 2005). For example, a US study of shelters showed that as many as 42% of the women in those shelters used alcohol or other drugs (Bennett and Lawson 1994).

This said, trauma symptoms arising from past violence, and the absence of a safe environment, are major obstacles to treatment and recovery (Brown 2000). Trauma survivors often feel that service providers are not safe or trustworthy, or that they will lose their children if they seek out services and treatment (which they often do) (Moses et al 2003).

**Reflective Questions: Can you think of any ways that a woman with mental health or substance use concerns might consider your service unsafe? If so, how could you address this to increase safety for women?**

**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" (Woman survivor quoted in Bland 2001).

One of the dominant myths surrounding women's substance use and relationship violence is the belief that their substance use caused the violence. This is not the case (Jacobs 1998), and it is now the established viewpoint, supported by research in the US and the UK, that women who experience relationship violence and who abuse substances are often likely to do so as a consequence of their abuse (The Stella Project 2005). Certainly, in the context of relationship violence and abuse, many women describe using substances to cope with and ameliorate the impact of this on their lives and to numb the emotional and physical pain:

**I** used to forget life, everything, to escape from every day... It just created more problems, a never-ending circle.... I look at the use of substances, stress levels and the experience of violence as all facets of the same problem, they are all connected."

"Hopelessness, escape, putting off what I have to deal with. It's the way I tolerate a situation. It's a reprieve... It helps me stuff and not deal with anger but it also helps me blow off my anger. I stuff up my anger so much that when I blow up I am insane and not able to deal with it. I'm afraid of what I might do. I have drank many times in my life to cope with feelings of abuse" (Greaves et al 2006).

Reflective Questions: Do you know a woman whose substance use makes her more "normal" and able to fit the expectations others have of her? Why is self-medicating with alcohol and illicit substances so highly stigmatized compared to using prescribed medications that often do the same job?

### 1.3.4 Substance Use, Pregnancy and Mothering

*"Many adults have times when they suffer from anxiety or depression, have relationships with partners that are unstable, drink alcohol, and increasing numbers have used drugs, both licit or illicit, but this does not mean they are poor parents. It is the extremity or combination of these situations, particularly the association with violence, which may impair children's health and development" (Cleaver et al in The Stella Project, 2005).*

Mothers receive overt criticism if they use substances, and are often faced with additional barriers in accessing services for their needs. Since the 1980s, substance use during pregnancy has been viewed as a substantial problem by policy makers and social commentators in the US and Canada, primarily because of the adverse effects on fetal development (Rutman et al 2000), and increased efforts are now being undertaken to identify substance-using mothers. It is estimated that 6–20% of all pregnant women use alcohol or drugs while pregnant (Motherisk 1996 in Rutman et al 2000), although numbers are difficult to determine accurately because screening for alcohol and drug use is not consistently done. Some studies also suggest that women

tend to under-report their use for a number of reasons including shame, fear of losing their children, lack of understanding of the effects of use on the health of the growing fetus, lack of childcare and access to treatment (Rutman et al 2000).

**R**eflective Questions: What are the fears concerning women, substance use and mothering? How does the idea of women using substances disrupt our view of the perfect mother? What evidence is there to support the reality of these fears?

Many barriers exist that limit the ability of women with substance use issues to access treatment, support and care, including:

- Fear of the child's apprehension by child welfare authorities
- Contradictions between abstinence and harm-reduction approaches
- Lack of fit between existing treatment options and pregnant women's needs
- Lack of availability of treatment when women seek or need it
- Inflexible rules and inaccessible care
- Unsupportive attitudes of practitioners
- Lack of resources that enable women to get to treatment (Rutman et al 2000)

Another possible barrier that a pregnant woman or new mother may face is violence and control in her relationship and the impact on her mental health and substance use. One in six pregnant women are abused during pregnancy (Middlesex-London Health Unit 2000). Twenty-six percent of new mothers between the ages of 13 and 17 experienced violence three months after the birth of their child (US General Accounting Office 2002). Pregnant women who are abused by their partners have a higher risk for alcohol and illicit drug use, depression and suicide attempts (Ibid). Homicide is the leading cause of death for pregnant and recently pregnant women, the majority of whom are killed by their intimate partners (Horon and Cheng 2001). The intersection of violence, mental health and substance use in pregnant women's lives is prevalent and the lack of inclusive and non-judging services is a critical barrier.

There is also a lack of viable childcare options while women seek or access treatment. Additionally, misunderstanding exists amongst many professionals of the impact of some substances on fetal and early childhood development, especially methadone.

**W**hile women's bodies are constantly under the gaze of medical and public scrutiny, when a woman is pregnant this scrutiny is heightened: "women's individual responsibility for the outcome of their pregnancies places a burden on them that is unrivalled in any other area of parental responsibility" (Boyd 2004).

There are very few services in BC that offer non-judgemental services for women with substance use who are pregnant or mothers. Exceptions are Fir Square at BC Women's Hospital and Health Centre in Vancouver, Sheway in the Downtown Eastside of Vancouver, and The Maxine Wright Centre in Surrey. These services all use a non-judgmental, empowering, strengths-based, harm reduction and women-centred approach. Women who participate in these types of programs have lower stress and are better able to stabilize their family situations, while their children show significantly lower infant mortality and higher birth weight, and are

more likely to be full term babies (Public Health Agency of Canada 2007). It needs to be stressed that these services are all urban based and services like this are not locally available for rural, isolated women.

Because of the widely held presumption that equates all substance use with harm to the developing fetus, substance use during pregnancy is commonly associated with child abuse and many mothers have lost custody after birth once their substance use is confirmed: "mothers-to-be are transformed into 'pregnant addicts' who are considered at best sick and at worst criminal. They are identified as 'those bad mothers' who do not adhere to the predominant ideologies of motherhood, and as such are caught up in practices that seek to 'treat' or 'punish' them" (Rutman et al 2000).

The idea of "good" or "bad" mothers is also replicated in charged fetus versus mother's rights debates that in the US has caused some commentators to suggest that: "the war on drugs has turned into a war on women" (Whiteford and Vitucci 1997 in Rutman et al 2000). However, as Rutman et al challenge, there has been no parallel critique or commentary on the situation of woman assault during pregnancy, and the consequent potential for damage to the fetus as a result; they argue that the mother-blaming focus of much of the public and policy commentary is an attempt to police and control women's behaviour.

### 1.3.5 Concurrent Disorders: The Double Whammy

"Concurrent disorders" is the term now used to describe the combination of mental health issues with substance use issues. "Dual diagnosis" used to be the favoured term and is still used occasionally in Canada but has largely now been replaced. Sometimes people with mental health concerns use substances as a way of treating their symptoms and distress. This has been described as self-medicating. For other people, the substance use may trigger the onset of mental health issues. This tends to happen when an individual is particularly vulnerable to developing mental health issues. Whatever the reason why an individual has both challenges, the reality of living with both creates huge difficulties, with additional barriers to be faced in accessing adequate treatment and housing and the stress of dealing with frequent relapses and hospitalisations. Some researchers also believe that combining drugs and alcohol with prescription medication increases the risk of severe drug reactions and the triggering or worsening of mental health conditions ([www.heretohelp.bc.ca](http://www.heretohelp.bc.ca)).

For those diagnosed with both mental health and substance use issues the stigma and discrimination experienced is pretty much a "double whammy," with anger, resentment and fear being the predominant public and social response, rather than compassion and support. The Health Canada publication *Best Practices: Concurrent Mental Health and Substance Use Disorders* (2002) documents the additional and severe stigma associated with having both substance use and mental health issues. Focus groups were held with current or former users of mental health and substance use services and many people commented strongly on the harmful and hurtful experience of being on the receiving end of judgemental attitudes. The following quote has been taken from these sessions:

*"I would really like to say the threat of being punished for being an addict and having any sort of mental illness, there always seems to be this threat hanging over that we are in some way responsible for this, we brought it on ourselves, and if we don't do A, B or C then our children will be taken and our welfare will be cut, our housing will be gone...There's just such an extraordinary threat and that just absolutely adds on to already extraordinary pressure, and I mean it's very demoralizing."*

According to Kaur (2004), those who experience both challenges: "have so internalised their shame that they often feel unjustified in speaking out for their rights." This makes them additionally vulnerable to having their rights violated in many domains.

**R**eflective Questions. Think of a woman you have worked with who had mental health and substance use concerns. What would she have said about the connections between the two? How did these additional challenges affect her safety? How did these additional challenges affect your work together?

### 1.3.6 Interconnecting Oppressions

The general prejudice and discrimination against women with substance use and mental health issues interconnect with other oppressions including heterosexism, racism, poverty and ableism. The connections between these elements are too numerous and complex to fully cover here, and each woman's experience will be different. Here are just a few examples of interconnections:

- **Colonization and substance use:** Aboriginal communities in Canada have been deeply damaged by colonization, residential schools, racism and poverty (see section on Particular Barriers to Safety for Aboriginal Women on Reserve in Safety and Support for Women in Rural/Remote Communities Who Are Dealing with Violence and Substance Use for more information). The rates of substance use among Aboriginal people are higher than the general population and Aboriginal women on and off reserve will face specific barriers to dealing with substance use issues.
- **Mental health and heterosexism:** In 1973, homosexuality was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM II) by the American Psychiatric Association. Until that time, and afterwards as well, gay men and lesbians were often institutionalized in Canada and the United States because of their sexual orientation. Lesbians and gays still risk institutionalization in other countries. Older lesbians and immigrants may have histories of psychiatric treatment because of their sexuality, and some younger women may also have experienced forced treatment, depending on their families' and doctors' perspectives. There are still widespread mistaken beliefs that lesbianism results from traumatic experiences with men, sexual abuse or other psychological trauma.
- **Mental health and transphobia:** The inclusion of Gender Identity Disorder in the DSM IV by definition labels any individual with a cross-gender identity as disordered or deficient. It reinforces stereotypical expressions of gender and does not recognize that gender variant individuals may be well adjusted and not require treatment from the mental health system. Gender Identity Disorder was expanded in the DSM IV to include children, which pathologizes normal childhood exploration of identity, roles and behaviours.
- **Poverty, ableism and health:** In BC the rate of poverty among single mothers has risen dramatically, due primarily to income assistance cuts and policy changes resulting in limits on what kinds of disability will be recognized for greater income exemptions. With 49% of all single mothers living in poverty (CCPA 2006), an increased number of women are homeless, engaged in survival sex, vulnerable to exploitative relationships and not receiving adequate health care.
- **Substance use and heterosexism:** For decades, lesbians and gay men have struggled to find places where they can meet in safety. For many lesbians, bars are an important part of life, a place where they can gather with friends and lovers. It may be difficult for a lesbian who is deeply involved in the bar culture to strategize about quitting drinking. It is important to understand the role that the bar may play in her life.

Whenever we work with a woman, we need to understand her experiences of violence, mental health and substance use in the context of living in a society that discriminates against and blames her for these experiences and also discriminates against her if in any way she does not represent the dominant culture. Exploring with the woman her understanding of how this intersects in her life, how it impacts her ability to stay safe, to access the resources she requires and how she navigates these barriers in her life is central in the work we do.

**T**hink about the five women below, and what your attitudes and societal attitudes might be about each woman. Who is seen as having an addiction, a problem, an issue? Who comes to the attention of the legal or mental health system? Whose substance use is not interfered with?

Catherine is a middle-class white woman with a good job and two children. She buys wine at the liquor store and drinks it every night. She is a single mother and has no close friends or family. She drinks to try to deal with the stress of an ongoing custody battle with her abusive ex-husband.

Edie is an Aboriginal woman who works in the sex trade and buys and injects heroin on the street. She has a long history of abuse and few trusted people in her life. Her children are in care. She has periodic angry outbursts in which she yells and threatens workers and other clients in the support groups she attends.

Marija is a new immigrant from Eastern Europe who has survived war trauma, including rape, and has vivid flashbacks and uses high doses of prescription medications to try to cope with them. She often believes that she is back in her home country or that people have followed her to Canada from her country.

Alisha is a teenaged African-Canadian woman who uses crystal meth at house parties and all of her friends use meth too. Her father is physically abusive to her and she is living part-time with her boyfriend, who sells meth.

Terry is a butch lesbian in her sixties who has been in psychiatric wards where she was "treated" for lesbianism. She would like to get help for her periods of deep depression but is fearful that she will risk being institutionalized against her will once anyone discovers her sexual orientation.

An invaluable resource for working with women on issues of violence from an anti-oppression perspective is Bonnie Burstow's book *Radical Feminist Therapy: Working in the Context of Violence* (see resource section for full reference). Burstow details anti-oppression work with survivors of the mental health system, with women who use substances and with survivors of all forms of abuse, and provides examples of inquiry that workers can use with lesbians, women with disabilities, Aboriginal women, Jewish women, Black women and immigrant women to unpack the impact of society's oppression on their experiences of violence and survival.

### **1.3.7 Why Anti-Violence Workers Must Address Substance Use and Mental Health Issues As Part of the Work with Women**

Many women live with all three issues of violence, mental health and substance use concerns. In a study undertaken in the UK (The Stella Project 2005), all those with problematic substance use who accessed anti-violence services saw a link between their substance use and their experiences of violence. Almost two-thirds of these women reported that they began their problematic substance use following experiences of violence within their relationships. Sexual and physical abuse in childhood is also strongly related to problems with substance use. Girls and women who have been sexually abused are more likely to use substances, to use

them earlier, and to use them more often and in greater quantities (Poole and Dell 2005). Women who have experienced physical and sexual abuse as children are at increased risk for a range of mental health problems, including depression, posttraumatic stress reactions, suicidal ideas and attempts, eating problems, self-harm and psychosis (see Veysey and Clark 2004; this will be explored in more depth in the section Broadening the Lens and Moving Towards Empowerment).

Testimony from women, research and analysis shows that women living with mental health issues, substance use and trauma/violence are more likely to have more severe difficulties and to use services more often than women with any one of these problems alone. The help-seeking histories of survivors with complex issues of substance use, violence and mental health issues are also often lengthy and complicated. Without coordinated services, the danger is that women will only access one type of service, despite being affected by all three issues.

Despite violence, substance use and mental health being interrelated concerns in many women's lives, there has been poor coordination among mental health, addiction and anti-violence services. This is due in part to differences in service philosophies between these three sectors, with the mental health and substance use sectors often taking a more individualistic and treatment oriented stance in their work with women than anti-violence services, which tend to emphasize safety planning, emotional and practical support, counselling, empowerment and anti-oppression work.

Mental health services often refuse treatment to a person with an active addiction and addiction services can be unwilling to treat addiction until the mental health problem has been dealt with (Kaur 2004). Anti-violence services have also commonly refused to provide services to women with significant substance use or mental health issues. All three sectors have been guilty of having "silo" thinking, in which each worker believes it is not her job to deal with the other two issues in a woman's life. The result is that women may be involved in mental health or substance use services without ever talking about their experiences of violence or creating safety plans. And women involved in anti-violence services may never discuss the impact of medication on their safety or ability to function in life or be forced to hide their substance use for fear of being excluded from services. Many women continue to be referred between systems, never really getting the holistic help they need.

*"For women with multiple vulnerabilities, particularly women diagnosed with serious mental illness who have been and/or are currently in abusive situations, and who use alcohol and other drugs, and may have a number of health problems, it is an overwhelming burden to navigate fragmented and competing systems. When a drug treatment program will not take a woman who self-injures, when a battered women shelter will not admit a woman who uses a drug, when a mental health program will not admit a woman diagnosed with serious mental illness with her children, when a medical provider speaks disrespectfully to a pregnant woman because of her substance abuse or doesn't listen to a woman ...attempting to discuss her abuse history because she 'is crazy,' then our systems and programs are doing harm" (Brown 1997).*

Because women who are problematic substance users have tended to be excluded from anti-violence services if they use drugs or alcohol, they have been particularly vulnerable to long-term experiences of violence and homelessness as they have fewer options of where to go for help, support and safety (The Stella Project 2004).

By refusing to work with women with substance use issues we continue the discrimination and consequent alienation and rejection that women face in many areas of their lives. Indeed, by not including them in our services we are in danger of excluding the women who most need acceptance and support to create safety and healing for themselves and their children. The Stella Project emphasizes that if we ignore drug or alcohol issues our clients may be:

- Less likely to leave a violent partner
- In greater danger of more severe violence
- More likely to have an ineffective criminal justice intervention
- More likely to lose their children
- Less likely to benefit from counselling
- Less likely to be admitted to a transition house or provided with permanent housing

Over the past decade there has been progress made in this area in Canada, the US and the UK, with each sector realising the need to work more closely with the others in order to provide a better service to their clients. There is now recognition in some services that all three sectors:

- Have an overlapping client base
- Have clients with similar psychosocial issues, such as guilt, shame, denial, depression and low self-esteem
- Address social exclusion and break down isolation

### 1.3.8 Tips for Working with an Anti-Oppression Approach

Whenever we work with a woman with substance use or mental health issues who has experienced violence, it is important to explore the reasons behind these issues. What has led to the substance use or mental health issue? How is it connected to the violence? Violence can be one traumatic event, a series of events, or a lifelong experience of oppression. When talking to a woman about substance use and mental health, we need to ask her and ask ourselves about how oppression may have affected her.

**A**t the BCASVACP 2006 Annual Training Forum, Dr Laura S Brown, an expert on trauma, discussed the limits of our understanding of PTSD, particularly our understanding of it as resulting from one very violent incident. She shared some of the work of her colleague, Maria Root, who has developed the concept of "insidious traumatization." This is the cumulative experience of trauma often experienced by members of oppressed groups. Experiences of discrimination, knowledge of violence against others in your community, etc, can build up, as Dr Brown explained it, "like drops of acid on a rock, until one drop shatters it." (Dr Brown was a speaker at the BCASVACP's 2006 Annual Training Forum; DVDs of her speech are available through the BCASVACP and the video can be watched online at [www.endingviolence.org](http://www.endingviolence.org).)

In general, the more privilege a person has in our society, the more they are able to hide their struggles. So, for example, a woman who is addicted to alcohol and who is white and has a home and a job will be less visible to the public than a woman of colour who lives on the street and uses heroin. The woman of colour who is on the street is more likely to face intervention from police and social workers and is more vulnerable to the scrutiny of the general public.

### Foundations for Support Work

The following assumptions can assist us in developing a model of support for women living out the intersectionality of oppression, violence, substance use and mental health challenges (excerpted and adapted from *Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups*. Maxine Harris and the Community Connections Trauma Workgroup. New York: The Free Press. 1998).

Each woman is the expert on her own experience and her own healing journey.  
Violence against women is the result of systemic oppression.

Many current dysfunctional behaviours and/or responses may have originated as legitimate coping responses to trauma or attachment issues.

Women who experienced repeated trauma in childhood were deprived of the opportunity to develop certain skills necessary for adult coping, including attachment.

Trauma severs core connections to one's family, one's community and ultimately to oneself.

Women who have been abused repeatedly feel powerless and unable to advocate for themselves.

Simply living in the body of an oppressed person is traumatic.

Building on these assumptions, we use a model of recovery that includes the following elements:

- Feminist anti-oppression analysis informs every aspect of our work.
- Safety is the most important goal, initially and throughout our work. Therefore, engaging in risk assessment and safety planning will be a priority.
- We try to ensure that her basic needs are being met and help her if she is unable to meet them herself; we advocate for her in the event her basic needs are not being met.
- We prioritize providing a safe place where she can come and be accepted as she is.
- We incorporate basic information on how systemic oppression of marginalized people contributes to and can compound women's experiences of trauma as well as negatively impact on their ability to heal/recover.
- We believe that trauma is disconnecting and that broken connections can only heal in the context of new connections, and therefore believe that trauma recovery is benefited by providing support work in a group format.
- We believe that attachment plays a significant role.
- We remember that profound mistrust and/or profound fear and/or psychosis (where a woman is having trouble getting a handle on what is real) may be less amenable to supportive, mid-range counselling and clinical treatment in general. See section on psychosis in Safety Planning for Women with Mental Health Issues for more information.
- We know that there is tremendous value in listening to a woman's experience, validating her feelings of fear, questioning what might be real and what might be a result of fear run amok.
- We include basic education about physical and sexual abuse and how current behaviours are linked to past abuses (impact of trauma).
- We reframe current responses as attempts to cope with unbearable trauma.
- We have an appreciation of the problem-solving attempts locked and hidden in certain repetitive behaviours.
- We include education focusing on basic skills in self-regulation, boundary maintenance, and communication.
- We include basic education about female sexuality and correcting misperceptions.
- We work to create a healing community by providing recovery services in a group format.
- We support rediscovery of and reconnection to lost memories, feelings and perceptions.
- We provide an opportunity for women to experience a sense of competence and resolution as they face their past trauma.
- We provide an opportunity for women to trust their own perceptions about reality and to receive validation from others for those perceptions.

## Self Reflection

One of the essential requirements for working in a non-oppressive manner is to be as self-aware as possible. As you begin or develop your work with women who use substances or have mental health issues, what comes up for you? What do you have in common with the women you work with? What biases and assumptions do you have? Remember, we all have biases and assumptions; we can get past them if we understand and stay aware of them.

It is not possible for us as anti-violence workers to come from an anti-oppression position if we see our clients as OTHER—as people with whom we have nothing in common. For example, if we believe that women who get into abusive relationships are stupid or weak, and we believe that we would never get into such a situation ourselves, we cannot have empathy for them. The same is true for working with women with mental health or substance use issues. We must be able to connect our own experience to theirs.

Our assumptions about substances and the women who use them might include:

- Drugs are bad. Women who use drugs are bad.
- Drugs are interesting and cool. Women who use them are cool unless they are too addicted to keep themselves together.
- Prescription medications are not bad, just the drugs you buy on the street.
- Alcohol is not as bad as drugs.
- Cigarettes and coffee are OK, because they are legal.
- Women who are addicted lack self-control.
- I have kicked my drug habit so everyone else should be able to do it in the same way and in the same timeframe.
- I have never had a drug habit so I can't understand these women. My addiction to coffee and sugar is completely different from their experience.
- Women who use drugs are criminals and should be dealt with that way.
- If women cared about their children, they would not use.

And about mental health:

- Mental illness is scary. Women who are mentally ill are violent, dangerous and unpredictable.
- Mental illness is a sign of weakness or laziness.
- Anyone can overcome mental illness if they try hard enough.

There also may be assumptions that are specific to anti-violence workers:

- Prescription anti-depressants are always harmful, and real feminist counsellors should tell clients not to use them.
- If a woman is using substances, she is doing what she needs to do to cope, and she will stop when she needs to. If I talk to her about it, it is interfering in her process.
- Mental health issues are a normal consequence of violence and can all be treated with counselling alone.

What are your assumptions? In this section and throughout the tool kit, we include suggestions about how to check in with yourself about your own biases.

Two-thirds of women accessing anti-violence services reported that they began their problematic substance use following experiences of violence in their relationships.

## Reflective Questions:

### Experiences of Discrimination

- Have you ever experienced stigma and discrimination? How did you feel? What could or did you do about it, if anything? Who was there to help?

### Counselling and Support Work

- What individual characteristics result in you feeling uncomfortable or unsure of how to communicate with someone?
- What do you find most challenging in women you work with? Anger, extreme withdrawal, unusual thoughts and perceptions... What are your fears here?

### Mental Health

- What have been the factors that informed your own personal views of mental health issues or mental illness? Do you have a friend or family member with mental health issues? What impact does it have on their life? How is their life different because of this, if at all? How has knowing them made a difference to your views about mental illness and mental health?
- Have you ever experienced depression or anxiety that disrupted your life? Have you taken anti-depressants or other psychotropic medication? Have you sought counselling? Have you been hopeless or suicidal? Have you worried about your own safety due to the state of your mental health? How do you feel about these experiences? Has anyone you loved or been close to had these experiences? If so what was the impact on you?
- What fears do you have about mental illness?

### Substance Use

- What substances do you use regularly? Occasionally? In the past but not now? What are/were the positives to use? What are/were the negatives?
- Have you known friends or family with drug or alcohol problems? How did their use affect them? How did it affect others? You? What feelings does thinking about this bring up for you now? Do these feelings affect your work with women with substance use issues? Do you need to do anything to keep a check on this? What could you do?

## Specialized Training

When workers are asked to work with women who have particular needs, we often say, "I need specialized training to deal with this." This may well be a valid response, but sometimes it arises from our fear of certain women—for example, women who are addicted to substances or who have mental illnesses.

It can be helpful to think of counselling and advocacy as having some key central tasks:

- Communicate with the woman
- Advocate for and with her
- Contextualize her experiences
- Empathize with her
- Assess her needs

If we come from a place of asking ourselves, "What do we need in order to do these tasks with a woman who has substance use or mental health issues?" this can help to normalize the work and lessen our "othering" of certain women.

We may need specialized training about mental health diagnoses or the effects of legal and illegal drugs. However, our core questions should be about how to do our central tasks most effectively with all women who come to us for services.

For example, I am working with a woman who believes that people are following her everywhere. She does not bathe or change her clothes very often and has a strong body odour. She often says things that I cannot understand and talks quickly and loudly. Sometimes she seems to see things that are not there. This is all challenging for me. Do I need specialized training? Or will it be helpful to focus on how I can communicate most effectively with her?

What does this raise for me? What fears do I have? What strengths can I identify? (See the Psychosis section in Safety Planning with Women with Mental Health Issues for more information.)

### Engaged Neutrality

Sometimes we resist working with women who face multiple challenges because we fear we do not know how to help her, and at some level we struggle with our fears about what happens to her when she leaves our office. It is risky to care about someone who is so at risk in the world. We fear that if she is badly hurt, we will feel pain because of our emotional involvement with her: we will suffer because of caring about her. We may also have conscious or unconscious worries that a woman will not "succeed." She will not leave her abusive relationship, stop using or achieve mental health. This "failure" will cause us pain and perhaps reflect badly on our work.

Particularly when working with high-risk women, we need to be careful about our own boundaries and the expectations or pressures we put on ourselves and on our clients. We cannot decide what success looks like, and then impose that definition on her. She needs to be at the centre of any plans for her life. If she determines goals for herself and does not meet them, we need to make sure that we have not created a personal investment in her acting in a certain way.

This is where the concept of engaged neutrality comes in. We can work with our clients in an engaged, caring manner; we can be concerned, worried or happy for them. However, if our own satisfaction with our work depends on our clients' actions, this is a set-up for failure. A client may feel pressure to please you, you may lose perspective on her situation, and you are more likely to feel negative and stressed about your work. So neutrality does not mean not caring; it means that we are not overly emotionally involved or invested. We take care of ourselves and meet our own needs for happiness or job satisfaction.

**N**otice your thoughts as you work with each woman. For example, if you are thinking, "She is hopeless," don't get mad at yourself, but just notice it. Then try replacing that thought with "I will do what I can for her," or something that works for you. It's important to acknowledge that we all have uncensored thoughts and judgements. It is essential to recognize these in ourselves, figure out where they are coming from and determine how we can work through them.

Success will look different for different women. For example, a woman who uses heroin and is homeless might completely stop using and find a job and an apartment. Another woman in that situation might cut down her drug use and find safer places to sleep at night. Another woman might continue to use heroin and live on the street and get some emotional relief from coming to appointments with you. This will depend on the barriers facing each woman: racism, poverty, history of trauma, etc. It will also depend on what each woman wants or is able to do. This is where our awareness of context and individual situations is essential.

An example of engaged neutrality: Use a harm reduction approach to open up room for important discussions. For example, asking a woman if she is open to hearing about suggestions for monitoring her blood alcohol level (fewer drinks spread out over more time, etc) could create an atmosphere where alcohol use can be discussed openly and honestly. There are practical ways to make substance use safer (see section on Moving Towards Safety: Using a Harm Reduction Framework for more information).

### **Asking and Listening**

In order to work in a respectful, effective manner with each woman, we need to know as precisely as possible what is happening for her and what she needs from us.

It helps to look at situations through a safety lens: what concerns does the woman have about her safety? What concerns do I have about her safety? The questions that I ask help me to understand what is going on in the woman's life and how I can help her. I need to remember that I do not know whether or not a mental health issue or substance use is a problem. It is up to the woman to tell me about how it affects her life (see section The Importance of Safe Conversations: Identifying Risk and Resources for more information).

### **1.3.9 An Important Note About Questions**

Intake procedures involve asking many questions, and questioning is a key safety assessment and counselling technique. As anti-violence workers, we have been trained to ask questions in a respectful manner. Working with women with mental health or substance use issues adds more layers to our questioning. We need to be very aware of our intent in asking questions. It is important to ask questions in order to find out how best to support her and to tailor our service delivery to her needs. We need to be careful not to ask questions for the purpose of pathologizing, categorizing or diagnosing her.

We can start by respecting a woman as an individual, before we begin asking her questions. The fact that she has come in to receive services does not give us the right to pry into her life. We need to be clear with her about why we are asking the questions and let her know that she can choose whether or not to answer. We also need to be clear in our own minds and with the woman, what notes (if any) we will make of her answers.

### **Using the Five W's and the H**

If we say a woman has a mental health issue, or that she uses substances, this doesn't really tell us much about her experience. The key questions to keep in mind when approaching this work are the five W's: Who? What? Where? Why? When? And the H: How?

The context that we are working within determines which questions we ask. It is imperative for a worker to be clear what information she may need in order to assist a woman in the work she wants to do. What questions would we ask if we were working on increasing safety, versus being able to be present for court and be seen as a credible witness, versus supporting a woman in working through her history of abuse?

In each of these service delivery contexts, when supporting a woman who is using substances, we will need to ask some of the following questions, and others would not be appropriate.

### Who?

- Who is she?
  - In her experience, how does her social identity (race, class, ethnicity, etc) affect her use of substances and access to services?
  - Who does she consider to be her community?
- Who supplies her with substances? Who uses with her? Is it someone who abuses her and/or forces her to use?
- Who lives with her?
- Who helps her when she is in trouble or faced with difficult situations? Who does she take care of and who will take over for her when she is at court?

### What?

- What substances is she using? Are they legal or illegal?
- What are the consequences she has experienced using these substances? What are the possible risks?
- What is she concerned about (if she is concerned)?
- What does she have to do to obtain these substances?

### Where?

- Where does she use substances?
- How much control does she have over the location?

### When?

- When does she use substances—how often? At certain events? After certain triggers? During the day or at night?

### Why?

- Why does she use? Is her partner pressuring or forcing her to use? Does the substance help her cope with emotions, memories, flashbacks, physical pain?

### How?

- How does she use her substance? Injection? Inhaling? Swallowing?
- How does substance use affect her? Does it change her behaviour? Does it make her sick?
- Has it affected her employment, her housing?
- How do people around her react to her using? Family? Friends? Partner? Community? Society in general?

What is important is to focus our questions on practical information that helps us plan for greater safety or to reach the goals she has identified. The answers will help identify the areas in which the woman needs support or further exploration. The answers will likely illuminate the ways in which social identity affect her experience and how she is seen by society and service providers, which will guide us in our work with her (see sections on Broadening the Lens and Moving Towards Empowerment, The Importance of Safe Conversations: Identifying Risk and Resources and Safety Planning with Women Using Substances for more on asking questions).

### Behaviours and Context

The reality is that labels may give us some clues to how best to support a woman, but what we really need to focus on is behaviours.

So a woman has been labelled as having mental health issues. What are her behaviours? What is she doing? What is she saying? How do her behaviours affect her? How does she understand her behaviours—what meaning do they have for her? How do they affect others? Where do they come from? In what context do they occur? What meaning can we draw from them?

For example, you are working with a woman who is convinced that there is a network of people who are following her. If we focus on the emotions we can see that she has a high level of fear. As opposed to focusing on debating the details of the story, how can we help her to manage her fear?

The challenge is to hear her experience enough to work with her on managing strong feelings and help her stay connected to practical strategies of staying safe, while neither affirming nor discounting her visions or beliefs. A reflection statement of "I know you are very scared right now, and I'd like to explore with you ways of staying as safe as possible while this is happening to you," may help the woman feel supported and move her towards what she can control (for more information see the section on Psychosis in Safety Planning with Women with Mental Health Issues).

Displaying anger is one of the most challenging behaviours for workers. We may be scared of anger, or resentful of it. Anger is very loaded for women and for survivors of abuse. We may classify all angry behaviour as abuse. It is valid for workers to expect that clients will not yell or swear at us, or threaten or hurt us, and it is also crucial that we see behaviours in context. If we are getting paid to work with a woman, and/or we have the power to refuse services to her, we have power over her. If she yells or swears at us, it is not abuse (a pattern of power and control). At the same time that we keep ourselves and the woman and other women safe, we need to pay attention to the cause of her anger. What is its source? Can we address the source of the anger now, or do we need to wait until she is calmer? What is possible? (See section Challenging Our Assumptions: Working with Women's Anger and Use of Violence for more information.)

## Conclusion

The links between violence, trauma and oppression and mental health and substance use are deep and complex. As anti-violence workers, we must acknowledge and continue to explore these links. Our work with all women needs to come from a place of respect and non-judgment if we are to help them to feel accepted and supported and more confident in moving forward to live free from violence and discrimination. This is not always easy for us, but the dangers of responding to women with substance use or mental health concerns from a place of fear, ignorance or trepidation are clear. Women will continue to hide their problems from those who may be able to help, placing them and their dependents at even greater risk. Responding instead with openness, tolerance, compassion and understanding will surely be a better support to them on their journey. Women with mental health and substance use concerns continue to remind us that it is by being treated with dignity and respect that they are able to come to accept themselves and begin to heal.

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Parents with Mental Illness: Their experiences and service needs  
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<http://www.psych.uic.edu/UICNRTC/Parents.PDF>

Parenting well when you are depressed: A complete resource for maintaining a healthy family  
<http://www.parentingwell.org/book.html>

Postpartum Support International  
<http://www.postpartum.net>

Selected readings pertaining to mothers with mental illness and their children  
National Research and Training Centre on Psychiatric Disability  
University of Illinois at Chicago  
<http://www.psych.uic.edu/UICNRTC/Readings.PDF>

Making time to talk: Advice for parents with mental illness  
NSF Scotland  
<http://www.nsfscot.org.uk/search/index.html>

# 1.4 Broadening the Lens and Moving Towards Empowerment

BY TESSA PARKES

*"I like it when people ask me what I want, particularly if I am taken seriously when I speak out. My old treatment team hated me. I argued with them all the time, and sometimes I got violent and threw things at them. The main problem was that we always disagreed, and I never got what I wanted. The old team reminded me of my family. They acted as if they knew what was best for me, but never asked how I felt or what I wanted. Believe me, I will fight tooth and nail against people who remind me of them. I care about being respected, and I demand to be taken seriously" ("Darlene" in Harris and Falot 2001).*

## 1.4.1 Trauma, Mental Health And Substance Use: Responding To The Connections

There is now substantial evidence that the stress caused by past or current/ongoing violence can affect all aspects of a person's life, including their emotional, mental and physical health and wellbeing. For women with abuse histories, the risk of developing mental health problems as an adult is heightened. This is true for depression, posttraumatic stress, suicidal ideation and attempts, poor self-esteem, eating disorders, self-inflicted injury, and psychosis, as well as for chronic medical conditions (Bassuk et al 1998; van der Kolk 1996; Herman 1992; Alexander and Muenzenmaier 1998; Reid et al 2005). Research shows that prolonged trauma may disrupt and alter brain chemistry, leading to the development of PTSD (see Herman 1992; Haskell 2003; Levine 2005). In addition to this, mental health problems such as depression, suicide attempts and self-harm are frequently symptoms or effects of abuse. Pre-existing mental health problems can also be exacerbated by abuse and violence in adult life. This subject is picked up again in the section on safety planning with women with mental health problems. (For further information on the connections between trauma, mental health and substance use please, see the references and resources at the end of this section and the BCASVACP's *Best Practices Manual*, McEvoy and Ziegler, 2006. For information on PTSD and trauma/mental health links see [www.sidran.org](http://www.sidran.org)).

Sexual and physical abuse in childhood is also strongly related to problems with substance use. Girls and women who have been sexually abused are more likely to use/misuse substances, to use them earlier and to use them more often and in greater quantities (Poole and Dell 2005). A significant proportion of women using transition houses, sexual assault centres and related anti-violence services experience problems related to substance use (Greaves et al 2006).

Despite these links, mental health and psychiatric services have historically ignored the connections between violence, trauma, mental health problems and substance use. This continues to the present day and is reinforced by the dominant bio-medical approach to mental illness and distress that looks for causes other than social and environmental factors. These services have also largely ignored the role played by other social inequalities like poverty, low social status, and the burden of care giving on women's mental health.

Women with mental health or substance use concerns have shared over and over again that what helps them is caring, supportive and safe relationships, and that these relationships are often not found in traditional health, mental health and substance use/addiction services. Particularly in a system that is increasingly drained of resources, women report having to wait months for an appointment with a psychiatrist and then having fifteen minutes to meet with them. Unless they access a community-based mental health or substance use/addiction service, women rarely are given space to talk about anything other than their mental health or sobriety. Women with long term service use and trauma histories are often perceived by the systems that serve them to be:

- manipulative
- controlling
- difficult
- immature
- attention-seeking
- secretive
- suspicious
- devious
- masochistic
- untreatable
- personality disordered (Inequality Agenda 2005)

Women survivors of abuse and violence with mental health and/or substance use concerns often internalize these stigmatizing views of themselves.

In addition to this, many commonly used mental health and substance use practices can trigger memories of prior traumatic experiences as well as traumatic stress responses to the practices themselves; for example, the use of:

- physical control and restraint procedures
- seclusion
- forced medication

In substance use settings the strongly confrontational approaches that have traditionally been used, which do not respect or support a women's right to go at her own pace with reducing substance use, can damage her fragile coping mechanisms and make her want to abandon her treatment efforts (Moses et al 2003). Be alert to the likelihood that a woman you are working with will have been retraumatized within mental health and addictions services, particularly if she has had extensive use of these services and has a history of childhood abuse.

**“I don't remember everything that happened before I was last hospitalized, but I do know that I had a lot of problems. I was experimenting with a lower dose of medication because I didn't like the side effects, my boyfriend was beating me up and my roommate had stolen my money. My case manager showed up with the police to take me to hospital. I hate the hospital, and I hate the police. Basically I like to be in charge of myself” (“Barbara” in Harris and Fallot 2001).**

Remember that many women with histories of using mental health services are mistrustful of staff and providers—not only within mental health services but also within all so-called “helping” services. This mistrust is often rooted in their experiences of coercion, retraumatization and degradation during their use of services. This must be kept in mind when talking to women about their mental health or substance use issues and care must be taken to avoid using language or practices that continue this disempowerment.

## Reflective Question: Safety needs to be present in your own relationship with a woman—how can you make this happen?

### 1.4.2 Supporting A Woman On Her Empowerment Journey

*"The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the woman and the creation of new connections"* (Herman 1992).

Human relationships are key to the healing process; particularly ones that are based on safety, value, respect and trust, that help women learn what they need and develop strategies for change. Traditionally, in the mental health system the treater is the expert, whereas in an advocacy system the survivors are the experts: this is central to the concepts of recovery and empowerment. An advocacy role means not viewing ourselves as experts on a woman's situation or on her choices.

For women who have disruptive or painful mental health symptoms, framing these symptoms in the context that contributed to them is essential. This helps to demystify and destigmatize these experiences. Asking a woman questions like: "What has happened to you in your life that has had an impact on your emotional health/mental health/anxiety/unhappiness?" can be helpful in this framing work (see below for more examples).

Women need support to build new skills to recover and heal from violence, trauma and abuse as well as from the negative impact of mental health problems, inadequate or pathologizing service provision and problematic substance use/addiction. The following skills are important ones to help a woman feel empowered<sup>1</sup>:

- Increase self-knowledge
- Enhance self-regulation and self-soothing
- Build self-esteem and self-trust
- Develop interpersonal skills such as limit setting and assertiveness
- Learn how to more clearly express and communicate her needs and desires
- Perceive others and situations more accurately
- Work towards mutuality and reciprocity in relationships
- Enhance her parenting and life skills (Harris and Fallot 2001)

Another key way in which anti-violence workers can diminish a woman survivor's feelings of helplessness, and increase her sense of empowerment, is by increasing her range of choice in all aspects of her life, not just the aspects directly related to the violence she is currently experiencing. Discussing options and choices are therefore essential activities that can help women empower themselves. Helping a woman develop stronger self-capacity is also one of the most effective ways of helping trauma symptoms and frequent crises. The more a woman survivor is able to...

- recognize, tolerate, modulate, and integrate her feelings
- feel internally connected over time to caring others
- feel deserving of life, love and attachment...

...the more she will be able to manage life and relationships, and to manage feelings and memories in particular (Inequality Agenda 2005).

<sup>1</sup> While these skills should enhance safety for women in their lives and in relationships, limit setting and increased assertiveness may make a woman less safe in the context of an abusive relationship.

Use the acronym RICH to remember the four most important things you can offer: respect, information, connection and hope (McEvoy and Ziegler 2006).

### 1.4.3 Questions To Ask To Broaden The Lens

*"If a woman is immobilized by depression or panic attacks, treatment is clearly warranted to help her be able to function and make choices that will ultimately lead her to safety. However, reframing these 'disorders' as understandable responses to terror and entrapment leads us to a different set of intervention strategies and helps us keep our focus on the real dangers she faces" (Brown 1997).*

Keeping in mind what we said in the previous section on the importance of developing a relationship with a woman before asking questions, and being clear regarding our intent in asking a question and the context in which we work, we have provided sample questions to consider asking a woman who has violence, mental health and/or substance use concerns. We have not included specific questions about violence because the assumption is that these will always be asked as part of your work with a woman. This list is intended to provide you with some ideas about how to invite an exploration of the possible influence of mental health issues and substance use issues on a woman's life. Counsellors and outreach workers would likely use more of the questions than a Community-Based Victim Assistance worker. But for all workers, it is beneficial to use some questions to help understand what gets in their way of safety (or dealing with the legal system). These questions aim to help us to see the complexity and interconnectedness of many life challenges and to keep the focus of our work clearly on supporting women's self-efficacy and empowerment.

#### Here and Now

- What do you see as the most important issue you need support with now?
- What risks and dangers are there in your life now?
- What additional stressors are you experiencing at the moment, unrelated to the abuse (problems at work, ill child at home)?
- What would you most like to change in your life right now, if anything? Have you thought about how you may be able to make this change? What barriers are there to making this change? Do you have ideas about how to get over these barriers?
- What additional support or resources do you most need right now?
- How can I help or support you now? Please let me know if this changes.

#### What Helps and What Harms

- Did you receive any help with surviving or coping in the past? What support was helpful to you?
- What are you doing to keep safe at the moment? What else do think would help you keep safe?
- Did you find any particular agencies helpful in the past? What or who was helpful in particular?
- Have any services gotten in the way of your safety or wellbeing? How? What kinds of treatment or interventions have most upset you?
- Have you receive a diagnosis for your problems? What do you understand this to mean?
- What do you think of this diagnosis? Do you have a different way of making sense of your problems or symptoms?
- Have you ever thought that the diagnosis/diagnoses you have received may be something to do with the past or current stress in your life?
- What treatments for your mental health/substance use have you received and did they help you? How? If not, why not?
- What current treatment are you having? Is this helpful? How could it be more helpful?

## Physical, Mental, Emotional and Spiritual Health

- How do you keep healthy or in balance at times of stress or crisis?
- Do you sometimes struggle to take care of yourself well? What helps you to look after yourself? What makes it more difficult? Do you need support with this?
- What makes you happy?
- What activities make your body feel good, give you energy or help you to feel good in general?
- What physical symptoms do you get when you become stressed or out of balance? How do you manage these? Would you like some extra help with these?
- Do you have beliefs that keep you going during the bad times? How do these help?
- Do you follow any spiritual or religious teachings? What difference do these make to your life? Do they help you make sense of life or give it meaning?

## Past Life, Survival and Supports

- What has happened to you in your life that has had an impact on your emotional health?
- Does the past still get in the way of your life or wellbeing now? If so, how?
- What helps you to cope?
- What people or things have supported you in your journey?
- How have you survived until now? What has helped?
- What strengths and personal resources do you have? When are you most able to draw on these?
- How do these help you to manage your life and life challenges?
- What extra supports would you really like in your life?

## Working Together

- How would you like me to work with you?
- What would you like me to be aware of in supporting you (from your past or from what you know works well or doesn't work)?
- Is there anything you would like us to change in the way we work together?

## Family History of Mental Health Problems<sup>2</sup>

- Has anyone in your family received a mental health diagnosis?
- How was this perceived by the person who received the diagnosis? By the rest of the family?
- What view does your family have of mental health? What do they think of psychiatric medications?
- If you grew up with a parent who was diagnosed with a mental illness, what was this like for you?

## Family History of Substance Use Problems

- Has anyone in your family had a substance use problem?
- How was this handled by the person concerned? By the rest of the family?
- What view does your family have of substance use? Of treatment for substance use?
- If you grew up with a parent who had a substance use problems, what was this like for you?

## Impact of Mental Health and/or Substance Use

- How does your mental health/substance use problem affect your life?
- What does mental wellbeing mean to you?
- How does your violent relationship affect your mental health/ substance use problems?
- Does your partner use your mental health need or substance use to harm or try to control you in any way? You may wish to give examples and see if any of these are going on for a woman...

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<sup>2</sup> In asking questions about family history try to draw out the variety of experiences and values in a women's family of origin as well as extended family. Usually there are multiple stories and perspectives which can support identifying both family resources and limiting beliefs. Using a genogram may be a helpful way to visually record the multiple perspectives that exist within the family.

- Controlling medication/ supply of substance? Forcing you to use with him? Stopping you attending services/groups/appointments? Attending appointments with you and speaking for you? Undermining your confidence and self-esteem, recovery efforts? Threatening to report you to child protection services, police, immigration? Threats to tell friends or family or strangers about your mental health diagnosis or substance use? How do you cope with this?
- Does your mental health/substance use problem affect your safety in any way? How? How do you try to keep safe? What support could help you with this?
- Have you thought about creating a crisis plan/advance agreement/Ulysses Agreement for times when you are in crisis? Would you like more information on this and on how to create one?
- Does your mental health/substance use problem mean that we should make some changes in how we work together? Is there enough time to talk through the things you want to discuss, for example? Do you need to take more breaks to be able to concentrate?
- Are there any changes you would like to make in your substance use? Do you have ideas about how you can make these changes? How confident are you in making these changes? What do you think would help?
- Would you like to receive additional support for your mental health or substance use? What kind of help would you most like? Do you have any concerns about using a specialist service? Is there anything I can do?

### Hopes, Dreams and Goals

- What hopes and dreams do you have for your life now? How about in the future?
- Do you have any goals or dreams you want to work on at the moment? What do you need to meet your goals or dreams? Would you like some information? How can I help with this?

### Parenting and Caring

- How are things with the children at the moment? Do you have any concerns about them?
- What supports you in your mothering?
- Is there anything you need to help you with your parenting? Is there anything I can help with?
- Have you got a plan in place for the children if you are in crisis? Would you like to create a plan for this? Can I help?

Note: For women who do not have custody or full time care of their children, their children or mothering may still be a concern or a topic they would like to discuss with you. Or it may not be—it may be too painful or raw. Your individual work with a woman should identify what questions concerning children are appropriate to include in this section. If you are not sure, try an open question that asks sensitively whether she would like to talk about her children.

Remember, women are the majority of primary care givers for other dependent relatives (this may include their abusive partner or family members of the abusive partner). This can be a cause of stress and can place multiple demands on a woman. You might like to ask: Do you care for anyone else? Are you managing this OK? What help could you use with this?

## 1.4.4 Responding To Women: Sharing Power And Responsibility

### Attending to the Connections

- Take into account the causes and contexts of women's mental health/substance use, including their traumatic histories. This means asking about the connections in her life, as she sees them. You can use some of the questions outlined in the piece above.

- **Helper to make connections** between structural and social inequalities like poverty, unemployment, demands of childrearing, and her mental health problems.
- **Don't make assumptions** about how issues or challenges are interconnected for her.
- **Provide information** on the impact of trauma (and other life experiences such as problems with attachment, neglect, living with a parent with substance use or mental health problems) on substance use and mental health issues<sup>3</sup>. Consider giving written information that can be taken away and read, if this is appropriate to the woman. Always ask permission before giving any information or possible explanations.
- **Take a positive attitude** no matter what unusual mental states the woman is experiencing or has experienced or what substance use has gone on in her life. If you are shocked or taken aback by anything a woman tells you, try not to show this to her in your responses: she needs acceptance, whatever has been going on for her.
- **Watch your language**—find out from the woman how she wants her problems or challenges to be described. Avoid medicalizing her problems or using labels. Questions like Mental health means different things to different people – what does it mean to you? can be helpful for opening up these kinds of discussions.

**I** notice the impact of language all the time now. There is a consciousness raising that happens. I think people rally around a new way of describing and thinking about themselves. At the same time, I can see them wilt when they are described in the same old words (Chris, a worker, in Harris and Falot 2001).

- **Helplessen her self-blame** for the violence and abuse, other trauma and her associated mental health or substance use problems. This can be done by using statements like: It is very common for women experiencing violence in their lives to... You are not alone in having these feelings/experiences... You are not to blame for the violence in your life or for trying to cope with it the best way you can.
- **Recognize and respond to her distress signals** – this may mean asking questions like: What are the warning signs that you are moving towards an emotional or mental crisis? What would you like me to do if or when this happens when we are working together?
- If you have to **report to other agencies** (e.g. child protection, mental health) make sure she knows that you are doing this and why. Involve her in making the call if possible. Tell her at the start of your work together the limits to confidentiality and what will happen if you need to break confidentiality. Give her reminders occasionally of the boundaries to your confidentiality (please see Empowering Strategies When Children Are At Risk section and *Records Management Guidelines: Protecting Privacy for Survivors of Violence*, available at [www.endingviolence.org](http://www.endingviolence.org)).

### Supporting Self-Efficacy

- **Honour where a woman is at**, her survival and coping, no matter how self-damaging some of a woman's behaviour has been. Remember all behaviour has meaning and can be viewed as adaptive coping strategies.
  - Offer affirmation and validation for how a woman has survived
  - Validate her courage, persistence, energy and power whenever you can
  - Acknowledge all her moves towards safety, however small and tentative
  - Emphasize hope and recovery in all your conversations with her.

<sup>3</sup> CAMH has some great booklets that do this. One of their factsheets is in Appendix 2 for an example of what is available. See [http://www.camh.net/Publications/CAMH\\_Publications/women\\_signs\\_common.html](http://www.camh.net/Publications/CAMH_Publications/women_signs_common.html).

- **Assumeshe is the expert on her life** and on the abuser’s behaviour, no matter what difficulties she has had or still has in terms of being in touch with reality, using substances or engaging in risky behaviours that put herself in danger. Recognize when she is not exercising/able to exercise her expertise on her life and support her to do the best she can.

### Addressing Safety–Both Internal and External

- Work with her to **maximize psychological and internal safety** as well as physical and external safety. Help her to identify, recognize and manage her warning signs, cues and triggers for using substances, mental health crisis, trauma memories, dissociation etc. Help her to develop new and effective coping and healing strategies when she is ready. Respond appropriately and sensitively to self-harming behaviours and learn from her what she needs at these times. Do not ask a woman to give up indirect ways of expressing her pain and anger (like self-harm) until she has found new ways to do this that work for her. Comment on your concerns for her safety and her risks to self without judging or trying to take control. Collaborate in problem solving, safety assessment and safety planning. There are many helpful strategies to inform this work in the sections Safety Planning with Women with Mental Health Problems and Safety Planning with Women Using Substances.

### Supporting the Development of Safe Relationships and Connections

- **Provide information** and enable **access to appropriate support groups** or networks and self-help groups. Talking with other women in similar situations or with similar past experiences is often very helpful, particularly integrated support groups that help women to recognize the interconnectedness of violence and substance use or violence and mental health or all three.

**I**f there are no such groups in your area, what could be done to start one up? Are there allies in other agencies that would be supportive or offer help? Are there other workers in your own agency who have an interest in running groups or creating more integrated supports for women? Are there support/self help groups already running that may be interested in helping you to develop an integrated group as part of their programs? Are there recovering women/consumers/survivors who would be interested in helping you to run a group like this? Are there funding streams in your local area that could be tapped into?

### Support Women Who Are Mothering

- For women who are mothering, **appreciate its importance in her life**, whether she has her children with her or not, and in spite of whatever is going on for her in her life around mental health or substance use challenges. Find out about local mental health and/or substance use treatment/harm reduction services that are flexible and accessible to mothers–develop relationships with these services. Ask a woman how you can best support her in her mothering (again, whether she has custody/full time care of her children or not). For example, she may want you to support her to be visited by her children when in hospital or treatment.

### Conclusion

*“And it feels at the beginning that it’s the end of the world, but it’s actually the beginning of a new life” (Bland 2001).*

Our work with women can be tremendously powerful and positive if we use the values, principles and approaches described above in our day-to-day interactions and relationships. Feel free to add to the lists of questions and responses and develop a more personalized approach that suits you, your service and the women you work with. Ask for feedback from the women you work with on a regular and informal basis. Don't be afraid of feedback! It is one of the best ways to improve our work with women survivors. While this section emphasizes asking a woman what she wants and needs, sometimes women will not know what they want and need and in these situations we will need to provide some gentle and compassionate direction. Finally, remember that the implementation of a few basic improvements can significantly help to overcome a woman's sense of powerlessness. For example, having a trusted confidante, feeling safe and having choices are huge developments for many women.

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# 1.5 Moving Towards Safety: Using A Harm Reduction Framework

BY TESSA PARKES

## 1.5.1 Introduction: What Is Harm Reduction?

One of the main goals when working with a woman who uses substances is supporting her to reduce harms related directly and indirectly to her substance use. A harm reduction approach acknowledges that most people struggle to make changes in their lives even when faced with extremely negative consequences for their safety, health and wellbeing. It focuses on harms rather than the substance use itself, enabling much wider windows of opportunity to be created for those who use substances and their supporters. It comes from the premise that small changes in use can reap big rewards in terms of the impact on a person's life.

The feminist principle of meeting a woman where she is at is central to the harm reduction approach. We acknowledge the complexity of women's lives while also being pragmatic and practical. Harm reduction allows service providers to work with women along a continuum of substance use, not just helping those who are able to abstain. It encourages creativity and the individualization of support, with the woman at the centre of her care.

### Harm Reduction Principles

- Pragmatism
- Human rights
- Focus on harms, not only the substance
- Provide a variety of options, doors and support
- Priority of immediate goals and working towards safety
- Involvement of women who use substances (British Columbia 2005)

A harm reduction approach acknowledges that most people struggle to make changes in their lives

## 1.5.2 Substance Use As A Continuum: Using A Harm Reduction Framework

The harm reduction approach views substance use as a continuum rather than in a dualistic way as beneficial or out of control (see text box below).

### Continuum Of Alcohol And Other Drug Use

*Social/Recreational Use*—Some of us use alcohol and other drugs in small amounts without major problems.

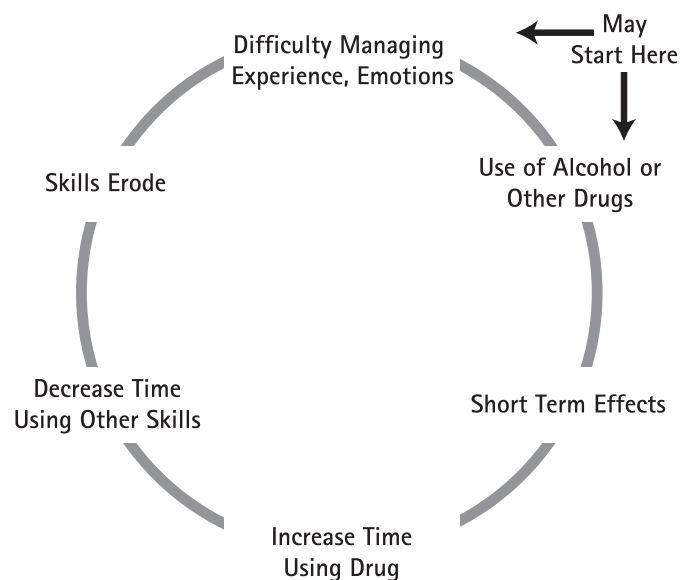
*Situational and Intensive Use*—We may use substances to cope with the demands of a certain situation. Or we may experience harm through consuming a large amount of drugs over a short period of time, or by engaging in continuous use over a number of days or weeks.

*Problem Use*—Problem use creates negative consequences in one or more areas of our lives.

*Dependence involves:*

- Excessive use in spite of harmful consequences and regular and serious problems
- Increasing focus on use
- Loss of control over how drug is used
- Experience of withdrawal symptoms when use is stopped (Poole and Members of the virtual community 2007a).

There are many explanations for the development of dependence or addiction. It is often helpful for women to see dependence as a cycle that begins with using substances as a way of coping with difficult experiences and feelings. While the substance may initially facilitate coping, over time it takes away individual power, choices, and abilities, as is shown in the diagram (Health Canada 1994: this has been placed in handout form in Appendix 1 for use in discussions with women about their substance use).



This understanding of cycles of dependence helps us to work constructively with a woman to talk about where she is on the continuum with different substances, make realistic plans for reducing risks, and make connections for changes in other life areas (Poole and Members of the virtual community 2007a). This work can help to reduce the shame and guilt associated with use and support her in her readiness to make changes in her life. Support is guided by the priorities set by the woman herself, which may include overall health and safety issues such as making changes in housing and relationships as well as substance specific concerns.

One of the most significant aspects of the continuum approach is recognizing that people can change their use of substances at any point, not only when they "hit bottom" (when use is causing significant problems). Even brief support can be helpful to a person at any point on the continuum of substance use (Miller 2006). It is important that services are provided in a non-judgmental way and that safety is created for women to be able to discuss the benefits of substance use, or the "positive intentions" (Kasl 1992) behind their use (to relax and calm me down, to help me deal with my anger, to help me forget), as well as the drawbacks or negative aspects of their use. Providing effective brief support on substance use issues in the context of anti-violence services can also help prevent the (further) development of substance use problems for women (Poole and Members of the virtual community 2007a).

Research also indicates that the relationship with the service provider and strengths that women bring to the counselling relationship are strong predictors of outcome. Collaborative support with women that draws on present-focused, appreciative and motivational interviewing/counselling<sup>1</sup> approaches can all be helpful. These approaches are pragmatic and strength (not problem) focused (Miller and Rollnick 2002)<sup>2</sup>.

**S**ervice providers are increasingly acknowledging that there is no one way to change one's patterns of problem substance use, or one treatment that is appropriate for everyone—there are many roads to change or recovery.

The treatment world is changing to offer new and shorter forms of treatment groups such as support for withdrawal management on an outpatient basis (daytox) and short-term (e.g. two-week) groups that help women discover new ways of managing their substance use and other problems.

One of the most significant aspects  
of the continuum approach is recognizing  
that people can change their use of  
substances at any point

1 Motivational interviewing is a directive, client-centered counselling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counselling, it is more focused and goal-directed. See <http://www.motivationalinterview.org/clinical/whatismi.html>.

2 Some warn that women in abusive relationships may not be able to act independently, so motivational approaches should therefore be used with caution.

## Good Practice Example:

An initiative that demonstrates a collaborative and empowering approach to helping women to make changes in their lives, including changes in substance use, is the *Honouring Ourselves and Healing Our Pasts* manual (Salmon and McDiarmid 2005). This was a resource created to support Aboriginal mothers in the Downtown Eastside of Vancouver who wanted to make changes in their substance use. The approach involves a woman creating a Wellness Plan with the help of a support person, based on the teachings of the Medicine Circle/Wheel. Medicine Circle/Wheel teachings include recognition that individual and community wellness have four inter-related aspects: physical, mental, emotional and spiritual wellness. The approach is built upon relationships of trust and respect between an Aboriginal woman and her support person. (This resource was developed by Downtown Eastside Healthy Communities, Mothers and Children Community Leaders Working Group, with the support of the Aboriginal Mothers Advisory Council and Local Advisory Committee).

### 1.5.3 The Stages Of Change Model

*"What can we do to support someone where they are? How can we leave paths open, build bridges?" (Alaska Network on Domestic Violence and Sexual Assault 2005)*

The stages of change model (Prochaska and DiClemente 1984) is a useful approach to help service providers understand the change process and match interventions with a woman's readiness to change. Many of the principles of harm reduction are reflected in this model, including starting where the woman is at and working with her to prioritize her goals<sup>3</sup>. This model suggests that change is a process, not an event, and in order for individuals to move forward in their behaviour change certain tasks need to be completed, such as recognizing there is a concern and working through ambivalence. The stages are:

- Pre-contemplation
- Contemplation
- Preparation
- Action
- Maintenance
- Relapse

In order to provide effective and supportive care for women it is important that the intervention matches the stage of change. Women may be at different stages of change or readiness depending on the substance or behaviour they have identified.

The following table by Urquhart and Poole (2007) offers suggestions for interventions at each stage of change.

<sup>3</sup> Some would argue that a drawback of this model is that it assumes that change is within the individual's ability and lacks an analysis of the role an abusive partner plays in ensuring a woman's continued substance use.

STAGE	READINESS FOR CHANGE	ROLE OF PROVIDER AND STRATEGIES FOR INTERVENTION
PRECONTEMPLATION	<p>May or may not be aware of reasons for change</p> <p>May not be ready, able or interested</p>	<ul style="list-style-type: none"> <li>• Provide information and raise doubt – increase the woman's perception of the risks and problems with current behaviour</li> <li>• Emphasize personal choice and control</li> <li>• Be empathic and offer hope for change</li> </ul> <p><b>Strategies:</b>  <b>General Information Exchange</b></p> <ul style="list-style-type: none"> <li>- Find out what she knows about the subject: "What have you heard about how cocaine impacts your mood/helps you deal with traumatic memories/helps you cope with the violence in your life?"</li> <li>- Important to ask permission: "Would you like to know more about the effect of ... on ....?"</li> <li>- Use general statements such as: "Generally women feel..." or "What happens to most women..."</li> <li>- Finish with inquiring about how the woman understands the information: "What do you make of this?"</li> <li>- <b>Gathering Information:</b> Tell me about a typical day. Where does your use of alcohol fit in?</li> </ul>
CONTEMPLATION	Considering change	<ul style="list-style-type: none"> <li>• Tip the balance: evoke reasons to change, risks of not changing; strengthen the woman's self efficacy for change</li> <li>• Review past successes and look for exceptions</li> </ul> <p><b>Strategies:</b></p> <ul style="list-style-type: none"> <li>- <b>Assess importance:</b> How important is it to you to (change)? If 0 was 'not important' and 10 was 'very important', what number would you give yourself?</li> <li>- <b>Assess confidence:</b> If you decided right now to (change) how confident do you feel about succeeding with this? If 0 was 'not confident' and 10 was 'very confident', what number would you give yourself?</li> <li>- What are some of the good / not so good things about your use of ____?</li> </ul>
PREPARATION	Ready to plan change	<ul style="list-style-type: none"> <li>• Help determine the best course of action to take in seeking change</li> <li>• Help to reduce barriers, set realistic goals and build on coping skills</li> </ul> <p><b>Strategies:</b></p> <ul style="list-style-type: none"> <li>- What kind of support do you need to be successful in reaching your goal?</li> <li>- What are you doing already to help you make changes?</li> </ul>
ACTION	Change is happening	<p><b>Support efforts</b></p> <ul style="list-style-type: none"> <li>• Anticipate and normalize relapse</li> <li>• Discuss relapse prevention strategies and problem-solving skills</li> <li>• Monitoring: evaluate and modify as needed</li> </ul> <p><b>Strategies:</b></p> <ul style="list-style-type: none"> <li>- What are some of the things you have done in the past to help you cope?</li> <li>- How do you plan to manage (high risk situation)?</li> </ul>
MAINTENANCE	Change has occurred	<ul style="list-style-type: none"> <li>• Show support and reinforce the positive changes made</li> <li>• Normalize the fact that some days will be better than others</li> <li>• Help strategize how to handle relapses or slips</li> <li>• Continue to check in on how she is managing and offer support</li> </ul> <p><b>Strategies:</b></p> <ul style="list-style-type: none"> <li>- What do you think you need to do to sustain the positive changes you have made?</li> <li>- <b>Keep the door open:</b> "You have made incredible changes, and some days will be better than others. I want you to know that my door is always open."</li> </ul>

When working with a woman to identify her own goals for change you can consider together:

- What kind of changes does she want to make?
- What timeframe does she want to achieve these changes in?
- Does she have the tools to cope with these changes?
- Are the changes achievable?
- What support does she need to make these changes?
- What resources or services does she need to make these changes?
- What are the barriers to making these changes?

In essence the approach could be described as "walking with" women, rather than telling them what they should be doing.

If a woman wants to make changes to her substance use, an advocacy-based counselling approach may be helpful, including:

- Repeating information
- Providing structure
- Simplifying goals
- Advocating for her inclusion in shelters and other service programs
- Understanding the impact of substances on safety planning (Alaska Network on Domestic Violence and Sexual Assault 2005)

One of the key aspects of this approach is to build self-efficacy, which is so relevant to a woman's confidence in being able to make changes in her life. Obviously, for women with trauma, mental health and/or substance use problems, their self-efficacy may be severely limited by external and internal factors. Safe, trusted, supportive and empowering relationships and experiences can help to build self-efficacy and confidence: anything you can do to provide a woman with these supports will be positive in enabling her work towards change.

**If the woman shares with you that she is continuing to use drugs or alcohol, the most important thing you can do as her support person is not to give up on her. Remind her that you are here for her, and will support her unconditionally (Salmon and McDiarmid 2005).**

#### 1.5.4 Working Towards Safety

**We do not need to be experts in drug and alcohol work to make a difference in this area with women: we just need to be willing to see substance use as part of many women's lives and therefore part of what we are there to help them with, should they want us to.**

A study by Greaves et al (2006) shows the benefits of providing support to women who experience violence and have substance use problems. This study explored the changes in use of alcohol and other substances by women when they moved into transition houses and then again three months later. The study found significant reductions in women's use of alcohol and stimulants across this time period (no reduction in use of depressants or tobacco) and levels of stress decreased. Changes in substance use were related to a number of factors such as financial concerns, mothering, relationships, levels of social support, and physical and mental health issues.

The study found that the assistance provided by the shelters played a pivotal role in helping women restructure their lives, including making changes in their use of substances. Some shelters used brief interventions, and some had more intensive approaches to helping women, but it is of note that women's substance use decreased irrespective of the level of intervention provided by the shelter. The researchers concluded that both brief and more substantive interventions could assist women in reflecting on and making changes to their substance use. Broader support (e.g. in finding housing, accessing income assistance) also contributed to helping women reduce or stop their substance use.

What the study indicates to the anti-violence sector is how positive our interventions with women around their substance use can be, no matter how brief our involvement is. If we help women make the connections between their substance use and the violence they have experienced in their lives, are supportive and non-judgmental, provide relevant information and referrals, then we are actually doing the kind of intervention that is desperately needed by women to help them make changes.

### **1.5.5 Practical Suggestions For Harm Reduction**

Here are a number of practical suggestions for working with women on their substance use from a harm reduction perspective:

#### **Asking the questions**

- Ask the questions about a woman's substance use in sensitive and non-judgmental ways and if she does not want to talk about her substance use, explore other ways to reduce harm and increase her safety.
- Frame substance use as a way of coping, to lessen the stigma attached to disclosing
- Find out if the woman is motivated to change any aspects of her substance use and her reasons for wanting to change.
- Find out what the woman wants to address first of all and how she wants to address it—it may or may not be substance specific.

#### **Help her make the connections**

- Normalize her experience and reactions.
- Help her to recognize the root causes of substance use in her life in a careful and sensitive way.
- Ask about what the substance offers her.
- Ask whether and how substances have contributed to her safety in her relationship and what role her abusive partner plays in her use of substances, including whether he would be supportive of changes in her use.
- Discuss the ways in which substances are affecting all areas of her life (health, family, supports, work etc.).
- Help her to recognize her triggers for substance use and, if she can, how to avoid or cope with them.
- Times of stress and transition are often times when women's substance use increases so these can be times for a woman to take stock of her substance use, to assess what it is currently giving her and what is taking away.
- Develop a safety plan for the woman and her children specifically for when she is using or planning to use (is there someone who can take care of the children?). See section Working on Safety with Aboriginal Women on Reserve.

**“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” (Woman survivor quoted in Alaska Network on Domestic Violence and Sexual Assault 2005).**

### Provide information

- Find out what information a woman already has on alcohol and drug use and find out what else she would like to know—you can then work on filling the gaps with her permission and appropriate to her literacy level.
- Look for opportunities to provide information on the effects of drugs and alcohol on health and wellbeing, how to use drugs or alcohol more safely, decrease risk and increase health and wellbeing in other ways (See resources at the end of this section for some sources).
- Offer information and perspectives that may encourage future change (i.e. outlining options for treatment or harm reduction)—ensure all the information you provide is factual, current and clear.
- Offer as many options and possibilities as possible.
- Ask permission before giving any information—this is respectful and makes the information easier to accept because it is seen as optional rather than recommended.
- Respond honestly and thoughtfully to any questions.

**Be Creative – Think about creating a binder full of current information on alcohol and drugs (from a harm reduction perspective) and other related topics such as pregnancy, child development and parenting, FASD, recovery and healing, to share with the women you are working with. Invite women to look through the binder on their own and take copies of the handouts they like. In the Honouring Ourselves and Healing Our Pasts (2005) manual, Aboriginal mothers suggested the following information be included in such a binder:**

- Information about the short and long term harmful effects of alcohol and drug exposure for fetal development, infants, older children and adults
- Common myths and misconceptions about substance use and pregnancy
- Indicators of high risk drinking and drug use, including issues related to metabolism of drugs and alcohol in women, lifestyle, food intake, nutrition, exercise and sleeping patterns
- Information about drinking, drug use and breastfeeding
- Information on the effects of methadone on fetal development
- Information on the effects of prescription and over-the-counter medication on babies and children
- Information on tobacco and fetal development and children
- Information on healthy infant and child development
- Information on healthy alternatives to drinks containing alcohol and caffeine
- Information on basic life skills such as budgeting
- Stories from other women who have been through the healing and recovery process

- Contact information for other useful services and resources
- Information on how to cope with difficult memories from childhood and on coping with grief and loss of childhood, abandonment, or how you were parented
- Skills for building friendships
- Ideas to cope with stress and to develop a positive outlook on life
- Other information resources for the binder could be
- Phone numbers for information hotlines
- Ways to access libraries and electronic libraries for information
- Provincial or federal support organizations like the Women's Addiction Foundation.

### Building readiness to change

- Do not assume the woman is ready to make changes in her substance use and don't assume she is not.
- Work with a woman to think about alternatives to substance use that may work for her and other ways to address the positive intentions or benefits she has identified regarding her substance use.
- Explore the pros and cons for making the changes—acknowledge the role of ambivalence.
- Explore a woman's confidence in being able to make the changes and try to build her confidence wherever possible.
- Focus on the harms, not the substance use itself.
- View your role as a person who may help to plant seeds of hope and change that may grow and flower later.
- Help a woman to develop other hobbies and interests.
- Help a woman to develop or re-establish additional life supports.
- Realize that alternative methods of coping often need to be found before a woman is able and willing to let go of the substance use.

**T**ry to keep your work together as positive as possible: changes to substance use do not usually happen overnight. Focus on what the woman is accomplishing now and the important steps she has already taken towards her healing and recovery (Salmon and McDiarmid, 2005).

### Supporting change

- Explore ways to decrease the amount of alcohol or drugs used at a time or to decrease the number of days in a week or month that a woman drinks or uses or look at changing the times, locations or situations of drinking or using.
- Acknowledge that change in, or recovery from, substance use is different for everyone—there is no one way to change patterns of problem substance use, or one “treatment” that is appropriate for everyone.
- Understand that even if a woman needs to take a break from using substances due to the negative effect on health and other life problems, it may not mean needing to be abstinent for the rest of her life.
- Realize that relapses are common and should be viewed as opportunities for learning rather than failures.
- Understand that lessons learned when making positive changes in one area of life may be helpful when applied to other life areas.
- Provide information about self-help and support groups or networks. For example, the 12-step approach taken by AA and other abstinence focused organizations may not be helpful for all women and has been experienced as disempowering by some. Alternative models such as Charlotte Kasl's (1992) 16-step model can be discussed.

## Conclusion

*“Survivors say again and again that they want staff to be human—not experts, nor messiahs or gurus, but fallible, compassionate, ethical, informed and hard-working professionals who can bear witness to their experiences and travel at least part of the way with them on a healing journey” (Saakvitne et al 2002).*

Taking a harm reduction approach to working with women with substance use concerns is not easy. It is certainly not about indifference or about ignoring or avoiding engaging with the substance use and its place in a woman's life. Working from a harm reduction approach relies heavily on our ability to support women creatively, compassionately and confidently while sometimes feeling fearful of the consequences of a woman's behaviour on her health and wellbeing. We need to recognize the complex relationship between violence and substance use, ensuring that women receive support that places safety first. The key is to be available to a woman in helping her with her substance use in the way that she most needs, to walk alongside her and not to give up on her.

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There is a good deal of information available online about women and alcohol, tobacco, prescription drugs, and illegal drugs. For reliable information on the short- and longer-term use of these drugs see the “Effects Series” on the website of the *Alberta Alcohol and Drug Abuse Commission (AADAC)*: <http://www.aadac.com/547.asp>.

The *Our Bodies, Ourselves* website offers information on drugs most commonly used by girls and women—alcohol, tobacco and other mood altering drugs such as ecstasy—as well as good information on other aspects of women’s health. <http://www.ourbodiesourselves.org/book>.

There are also many online resources available on pregnancy and substance use. The *AADAC Effects Series* and a booklet available from the Centre for Addiction and Mental Health in Ontario entitled “*Is It Safe for My Baby?*” provide excellent information for women on the risks of substance use in pregnancy Available online: [http://www.camh.net/About\\_Addiction\\_Mental\\_Health/Drug\\_and\\_Addiction\\_Information/Safe\\_Baby/index.html](http://www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/Safe_Baby/index.html).

Also see the resources at [www.addictionpregnancy.ca/home.html](http://www.addictionpregnancy.ca/home.html).

# 1.6 Taking Care of Ourselves: The Impact of Working within Systems

BY MAGGIE ZIEGLER

Advocacy, support and counselling for survivors of violence are delivered within challenging social, political and economic systems. The reduction or elimination of services, accompanied by increases in poverty and homelessness, increases pressure on our services. Lack of resources and referrals, financial constraints and intersecting oppressions affect the women we work with and ourselves. There is a constant struggle to do more with less.

The term “vicarious traumatization” was coined in 1990 by Lisa McCann and Laurie Pearlman to describe how our exposure to trauma survivors and their stories changes us. There are a number of factors contributing to vicarious traumatization (VT), and one of them is the environment in which we work. This has as powerful an impact as the other causes (our exposure to survivors and their stories, the nature of our work and workplace, and our own experiences and histories). In fact, many people involved in anti-violence work now speak of their reactions to the unsupportive and deteriorating systems in which they work as more difficult than their contact with survivors. In order to address the systemic aspect of VT we need to understand the situation, identify our response, examine how systemic VT affects us and our work, and find both individual and organizational ways to address this problem.

## 1.6.1 The Social/Cultural/Political Context

- What are the systemic obstacles to my work?
- How does the community respond to the work my organization and I are doing?
- How does the community view the population I serve? How does media, etc. view the issue of violence against women?
- What are other social/political factors influencing my ability to do my work?

Making a list of your answers to these questions identifies and honours the difficult environment in which you work. Some items may be familiar, some new, but together they offer a validating of your experience. Taking the time to name and reflect on the breadth of the systemic challenges that you face every day is important. You and your co-workers could make separate lists and then compare them.

## 1.6.2 Our Response To The Context Of Our Work

- How do the systemic obstacles and community responses that I have identified affect me?
  - What feelings do they bring up in me?
  - How do they affect the way I think about myself and the women I work with? Have they affected the way I make meaning of the world?
  - What happens in my body when I contemplate these obstacles? Do I have problems sleeping, anxiety, depression, etc?
- Which are the most troublesome or problematic of these responses for me? Why?

Our responses are varied and there is no right answer. Whatever you feel, think and experience in your body is what you need to pay attention to. Laurie Pearlman and Karen Saakvitne do suggest, "Perhaps the most insidious impact of vicarious traumatization is its assault on our hope and idealism." This assault on hope is perhaps strongest in the systemic aspect (i.e. systemic barriers to change and their accompanying impacts and challenges) of vicarious trauma.

### 1.6.3 How Systemic Vicarious Trauma Affects My Work

- Am I cynical and discouraged about the system's ability to support survivors? Does this affect how I talk with survivors?
- Do I engage in conversations with co-workers about the obstacles to women's safety and health that leave me feeling more discouraged?
- Do I go through the motions of advocacy or referral without much hope? What does this communicate to the survivor?

We need to consider that our own systemic vicarious trauma can affect the women we work with. If VT is the *accumulated* impact of working with survivors, then systemic VT is the *accumulated* impact of being unable to assist women with the resources and referrals that they need. Addressing the impact on ourselves avoids infecting others with our anger, despair and frustration. When we feel weighed down, women sense our powerlessness and feel increasingly helpless themselves. Taking care of yourself helps everyone.

### 1.6.4 What I Can Do To Take Care Of Myself

First, identify and acknowledge the causes and impact of systemic VT

- What kind of self-care activities can help you in daily management of VT?
- What kind of activities can give you time-outs, or opportunities to just escape?
- What would help transform your systemic VT?

Pearlman and Saakvitne offer an ABC model to address VT: bringing into our lives Awareness (attunement to our needs, limits, emotions and resources), Balance (inner balancing of the multiple aspects of ourselves and outer balance of activities) and Connection (to oneself, to others and to something larger). Consider an ABC plan both for work and for your private life.

Transformation requires shifting the VT related loss of hope and meaning. False hope or naïve optimism isn't useful, but finding ways of being and thinking that bring a quality of equanimity and restore a sense of possibility are essential. This might come from time in nature, deepening connections with others, spiritual practice and/or activism.

### 1.6.5 How My Workplace/Agency Can Address Systemic Vicarious Traumatization

- Acknowledge systemic VT as significant
- Identify ways in which talk about systemic obstacles increases discouragement, and find ways of talking about systemic VT that are meaningful and supportive
- Agree on collective actions that can be empowering group responses to systemic obstacles

It is critical to find collective and empowering responses that avoid the shared complaining that can entrench our VT. Establishing specific time-limited procedures is helpful. Perhaps allowing ten minutes at a staff meeting or peer consultation session for venting could release energy. Or maybe you just need a few minutes to talk

about your responses to systemic obstacles, silently witnessed by colleagues or friends. Their attentiveness deepens connection and avoids tag team dynamics of depressing stories. And involvement in collective activities to address societal imbalances is the best antidote of all.

### **1.6.6 References, Resources And Further Reading**

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