

4.1 Survivor's and Service Provider's Stories

A Survivor's Story

I had never talked about my past with a professional, but when my condition started to deteriorate, I came to see this counsellor. I was apprehensive in the beginning, but was determined to change my situation. I met this counsellor within three days of my call to her office.

My biggest challenge was my inability to recognize my own strengths, which my counsellor helped me to discover. Other than, that the scariest part was when I was asked for the first time to accept and acknowledge that I was having a flashback. I thought I might have a panic attack, but the counsellor's presence and my "safe place" and the safety of my own home helped me immensely. I would say that the most helpful component of my treatment was the gently directive approach of my counsellor. Her kindness and soft-spokenness were also very helpful; I felt from the first session that I could trust her completely.

Controlling my breath whenever I had chest pains and knotted stomach was very relieving; the relaxation techniques and the visualization are still my daily routine. Another relief is that I will not have to see my ex-husband face-to-face and everything will be sorted out by the lawyer. But who cares; even if I did have to see him, I am not scared anymore. That was then and this is now.

I still see my doctor on regular basis but do not take any medication for my anxiety. I do take medication for my age-related physical complications. I have lots of friends now and keep myself really busy socially as well as around the house.

It's been eight months since I stopped seeing my counsellor but I still do all the things she taught me and I feel great.

I would say that the most helpful component of my treatment was the gently directive approach of my counsellor.

A Service Provider's Story

My client is a 65-year-old woman who was seeking support to deal with her historical issues of physical and emotional abuse. She stated that she had been diagnosed with an anxiety disorder and panic attacks. She had been on anti-depressants and benzodiazepines (Clonazepam and Alprozelam) for the past 15 years. The client was resistant to involvement of the mental health unit and that was respected. However, she was encouraged to visit her family doctor on a regular basis.

She stated that she was divorced 25 years ago and had had no contact with the offender since then, but in the near future, she might have to face him in the court to get her share of his pension. This triggered her anxiety disorder, and her symptoms became more prominent and intrusive and affected her daily coping. Her prominent somatic symptoms were: pounding heart, hot flushes, shortness of breath, tingling sensations and "knotted stomach."

She was offered one-on-one sessions. The counselling relationship started with creating a safe environment for her so that she could re-frame her story without any fears. For a stronger sense of safety, the client was offered these sessions in her own home, in addition to developing resources such as containment, going to a safe place and breathing through discomfort. The triggers were identified and the relationship between her mental health and her past experiences of abuse was explored. The challenges in the process were that she had never been educated about her mental health, nor provided with any supportive counselling previously, and lacked effective coping skills for her symptoms.

Along with counselling, self-care techniques were provided to the client in the form of relaxation and meditation, yogic breathing, biofeedback and visualization. A lot of education was provided on all issues of concern, and material was collected from mental health units also. The client's goals were met within a time frame of months. She began to recognize her own strengths and even now (after eight months of closure) she follows her self-care routine. I would like to express my gratitude and admiration for this client for being so motivated and committed to the counselling process.

4.2 Working Effectively with Immigrant and Refugee Women on Safety

BY KASHMIR BESLA

4.2.1 Immigrant And Refugee Women And Mental Health

Immigrant and refugee women face many challenges as they integrate into mainstream culture. Women of colour emigrating from non-English-speaking countries can experience many difficulties. Immigrant and refugee women often have many struggles with employment, language barriers and housing. They may be experiencing financial difficulties and lack a support network. When women find themselves struggling with mental health issues, this can be a frightening and unsettling time for them. Their only support may be a family physician, and the experience can be isolating. Like all women in this situation, immigrant and refugee women often do not know what is going on for them, and it can take a long time for an accurate diagnosis.

Immigrant and refugee women may not be appropriately diagnosed due to a lack of culturally and linguistically appropriate and accessible diagnostic tools. For example, learning and developmental disabilities often go unacknowledged by professionals, as there may not be an assessment tool in her language or at her level of literacy.

Immigrant and refugee women often feel that something is not quite right with how they are feeling and are not able to express their experiences. They may even attempt to hide their fears because they do not want anyone to think that there is anything wrong with them. Women will often try to talk themselves out of feeling in ways they believe they should not feel. The practical tasks of adjustment to a new country are difficult enough, and it is often too much to acknowledge internal difficulties.

As with most people, immigrant and refugee women often have little understanding of mental health issues. Some may attribute their experiences of violence and mental health issues to karma or fate, and this view could be encouraged by those around them. Attributing these experiences to karma or fate, immigrant and refugee women assume blame for their experiences and become more isolated in dealing with them. Many people believe that little can be done to help someone with a mental health problem. Issues of mental health are generally not discussed in most cultures, creating many myths and misconceptions of what mental health and mental health issues really are. Historically, in some cultures mental illness was believed to be associated with demons that had possessed the mind and body of its victims. Such beliefs perpetuate further misconceptions and isolation. Even present-day language used to describe mental health problems can be disrespectful and unkind.

The stigma of having mental health issues can be overwhelming for many immigrant and refugee women. As with many other areas of their lives, they are taught to "save face," and having mental health issues may appear to bring unwanted attention to them. Their families and partners may not understand what is

happening, and their own misconceptions of mental health issues may affect how they relate to the woman. One woman that I worked with said that her family felt that she was damaged because her brain was not working the way it was supposed to. This attitude towards mental health problems caused the woman to want to hide her struggles even more. Between trying to settle into the western culture and taking care of the family, and the added challenge of mental health problems, women often have a difficult time trying to balance and understand everything.

Many women are looking for fast solutions for their problems. On numerous occasions I have heard women insist on a quick remedy for their mental health issues. Many believe that the professional should be able to make them feel better right away. Other women put too much emphasis on medication and believe that the "magic pill" should improve their lives. Some immigrant and refugee women believe that Western medicine should be able to cure them quickly of their ailments. When women are struggling with treatment options, it can be reassuring when their worker validates the positive coping skills that they are already using, such as prayer, exercise or another modality that is culturally normative. Women often feel isolated when they are going through an experience that they believe others cannot relate to. It is helpful to remind women that there are many other women that are having similar experiences and are able to manage their lives. Women also need to be educated as to how their management of their mental health issues will affect their children. Women can be guided as to the kinds of conversations they can have with their children regarding parental mental health issues. These conversations can help put children at ease and have a better understanding of their mothers' experience.

Immigrant and refugee women are often dependent on family physicians as a form of support. They sometimes require family members to help them with language skills to be able to have a conversation with the doctor. In the name of convenience, family members are often asked to interpret, but in order to have accurate interpretation, professional interpreters should be used. This allows for accurate information going from the woman to the doctor and back to the woman. When professional interpreters are not available, it is helpful to brainstorm with the woman who in her extended circle of supports (friends, neighbour, someone from temple, etc) could be a safe and trusted interpreter. The issue of interpretation becomes critical when violence and other forms of power and control are present in the home, as a woman's safety could be highly compromised if a family member provides interpretation or the person interpreting does not maintain confidentiality. Family members may misinterpret information, may not relay information correctly or may prevent a woman from speaking honestly about her experiences.

Immigrant and refugee women who have experienced trauma as a result of war, natural disasters, physical or sexual assault, prison and other life experiences and are experiencing symptoms of complex post traumatic stress will feel especially challenged. They may feel that their nightmares and flashbacks should dissipate now that they are in a safe country. They will need to learn that their symptoms can last for a long time and there are techniques to try to cope. They may require advocacy and education services with their family members and/or other service providers to delineate their experiences as symptomatic of the torture or extreme trauma they have endured rather than interpreting their symptoms as a mental illness.

4.2.2 Mental Health Case Study

When I think about immigrant and refugee women and mental health, one woman that I worked with many years ago comes to mind. She had immigrated to Canada shortly after marrying her husband, who had sponsored her from a country in Asia. She moved into a home with his parents, his brother and his sister. The first few months of the marriage were all right, but soon after, the woman said that she was being belittled and put down by her mother-in-law. The husband felt that his wife was being disrespectful to his mother, so tension between the couple began to build over the years. The woman gave birth to a daughter and was told

by her mother-in-law that she was no good because she had a female child. She would often call her crazy and stupid. The husband felt caught between his mother and his wife, but chose to believe his mother's version of events over his wife's. The anger between the couple escalated and the husband hit his wife. This happened sporadically for a few years until the woman felt she had to leave her home in order to protect herself and her young child. She also felt that she was being pushed out of the home by the family's verbal intimidation and abuse. The mother and child moved into a place of their own, barely surviving on the little income that the woman had.

I met the woman when the child was seven years old and began to display unusual and disturbing behaviours at school. She was insisting that she had magic powers, she was talking to trees, and she was isolated from her peers because of her unusual behaviours and lack of social skills. In working with the mother, it became clear almost immediately that she was experiencing difficulty in her life, and that the mother's experiences were influencing the daughter's view of the world. After many sessions of working together and building trust, she told me about her ability to see things that I could not see, she talked about her magical powers, and provided great detail about "bad men" that broke into her home and tried to hurt her and her child. I worked with this woman for many months to try to help her discover what was real and what was not real. She was certain that her reality was much more believable than mine.

As a result of other disclosures that the daughter made, she was removed from her mother's care and was living with her father. He had remarried and appeared to have a good relationship with his wife. The mother was very angry and sad at the time, but over time, she accepted that she had not been able to care or provide for her child in the way that she felt she should. The mother unfortunately was unable to admit or acknowledge her mental health issues and refused to receive further assistance from professionals. She does continue to have supervised visits with her daughter, and has tried to maintain a relationship with the daughter she loves dearly.

In my work with her, she made it clear that she did not want to be viewed as a "crazy lady" because she was well known at her place of worship and she did not want people to see her in a negative light. She did not want to see a psychiatrist or any type of medical doctor. She felt she had the means to take care of herself and she did not require any medication for her visions. I worked with this woman for many months and recognized that she had many skills and talents, and that she would not be defined by a mental health issue. She was able to function in most parts of her life. She had a few friends and she practiced self-care. Although she had a serious mental health issue, she had managed to create a life that she was comfortable with, and she would access further services when she was ready to.

4.2.3 Ways For Workers To Engage With Immigrant And Refugee Women Who Experience Mental Health Issues

Meet The Client Where She Is At

Receiving assistance from service providers can require a great deal of effort on the part of immigrant and refugee women. Refugee women in particular may have had unsafe experiences with people in authority and may be very wary of connecting with people in power. This may be particularly evident with law enforcement personnel and court workers. Being aware of this and other barriers and recognizing her effort and fear can put women at ease, and remind them of their ability to help themselves. Don't rush into issues without taking the time to build trust and strengthen the relationship. Immigrant and refugee women are sometimes faced with language barriers, and may not know where they can receive service or what is expected of them once they do receive service. A woman may not have support from her family (or may not have family available in the country), as they do not want her to share her struggles with anyone for fear of how the family will be perceived.

Be Aware Of What You Bring Into The Room

It goes without saying that the service provider and client relationship is an imbalance of power. The service provider is in a position of power and the client may be feeling vulnerable. Naming this to the client can be helpful as it tells the client that you have also recognized the imbalance. Being aware of what the service provider brings into the room as far as ethnicity, the way she is dressed, her tone of voice and body language can influence how the client perceives she will relate to the worker.

Facilitate Open And Respectful Discussion

When working with immigrant and refugee women, many questions about the clients' worldview will arise. Asking questions about their experience is important, but remember to ask yourself, "For whose benefit am I asking this question?" I recall working with a young South Asian woman, and her telling me that she was also seeing a psychologist once a month. She said that she did not find it useful to talk to him because their sessions were spent with her explaining different aspects of her culture to him. Instead of talking about the serious childhood abuse she experienced, or her medications, or her depression, he wanted to know more about her culture. He did not give her an explanation for this request, nor did she find it useful in addressing her depression.

Challenge Misconceptions And Stereotypes

Like most cultures, immigrant and refugee women have misconceptions and stereotypes about what mental health issues are about. They may be carrying these ideas from what they have heard and what they have learned. It is important for a woman to know that having a mental health issue is only one part of her life and not the whole of who she is. Stigma about mental health issues is a form of disrespect, and that disrespect needs to be challenged and addressed.

What Other Challenges Of The Migration And Settlement Process Is She Struggling With?

Immigrating to and settling into a new country can be a challenging process. Ask the woman what other challenges of the migration and settlement process is she struggling with. Talk about what she is experiencing, and how these experiences are affecting her mental health. Is she seeking employment, attending school or looking for housing?

Find Out What Is Happening At Home

Family life can have a positive or negative affect on women's health. Ask the woman what is happening at home. Is she raising children, is she married, or a single parent? Is she taking care of others in the home? Does she stay home alone, or does she have people around her throughout the day? Are there issues of violence or abuse in the home? If there are, a safety plan should be put in place. A safety plan that is used with non-immigrant women is useful for all women. There are other issues to consider as well. The resources in mainstream culture may not be ones that the woman is familiar with, or would consider. For example, would she call 911, does she understand what a transition house is, does she know about victim services and counselling supports? Does she believe that information is kept confidential and will not be released to her partner or community, and does she know what the limits to confidentiality are? Each woman may need a specialized safety plan, one which she is most likely to access in a time of crisis. If the ideas created in the safety plan are those of the worker's and not the client's, she is less likely to follow through. It is important to think outside the box and involve the woman in her own safety plan.

Empower Women To Care For Themselves

Empowering women to care for themselves is the best tool that workers can provide. If a woman recognizes the value of learning to put herself first, she will be better able to cope with all of the other challenges that life presents. Most women are not encouraged to do this, and immigrant and refugee women are often even less so. Encourage her to use spirituality, meditation and prayer if these are her preferred ways of taking care of herself. Learning the value of self-care will be a gift for life, and one that will help manage her mental health issues.

Aim For A Holistic Approach

Not all methods of counselling or support work for all people. It is important to try a variety of approaches when working with immigrant and refugee women. Simple, effective tools of self-care and management are the most effective. The concept of speaking with strangers to manage one's life is still a newer phenomenon for most cultures. Let the woman know that she has choices, and that she can choose to take care of herself in ways that work for her. Many people either have friends and family for support, or they simply do not speak about certain subjects. Helping the woman to find the approach that works best for her will be the most helpful thing the worker can do.

Identify Supportive Friends And Family

Helping immigrant and refugee women to identify a list of people they can count on to help them through their journey is good way of ensuring that the woman will have others to turn to when you are not available. Most professional relationships are time limited, so it is important to put people in place for her to access. Sometimes women forget that they have a trusted friend that would want to help them out.

Talk About What It Means For The Woman To Have Mental Health Concerns

Shame can be a powerful influence in the lives of immigrant and refugee women. Helping to take that shame away from mental health issues is an important conversation to have with women. This experience does not have to be shameful, it can be empowering.

Refer To Culturally Appropriate Service Providers

Services for immigrant and refugee women experiencing mental health issues are limited, but it is important to familiarize yourself with any in your area. Sometimes a woman feels more comfortable speaking to a counsellor in her first language, as opposed to trying to express herself through broken English. It may also be a better fit because the counsellor will have a better idea about the culture, and may be more effective in assisting the women. On the other hand, some women do not want to see a counsellor from their own ethnicity for fear that information will not be kept confidential. Either way, the choice should be up to the woman, if options are available. Try not to make any assumptions about what would be most helpful.

Ask For Feedback

It is always good practice to ask for feedback from clients as to how they are experiencing your work together. Is she finding the sessions useful, is she getting what she needs, or is a different approach required? Many immigrant and refugee women will view the service provider as the expert and believe that whatever suggestions or ideas are presented will be most useful. They may even tell the service provider that they will go along with the advice that they are offered because they believe that they are unable to make good decisions in their current circumstances. Women have often said to workers, "Just tell me what I should do in this situation."

Some women will benefit from step by step written information, which they can take home and practice throughout the week. This would be helpful when women are working on self-care, or trying to create new routines. Talking about feelings, can feel too abstract for some women, so having information to take home will be more useful. Again, this is about having a respectful dialogue with the client to ensure that she is getting what she needs from the service.

It is always important to ask the woman what she hopes to achieve in working with you, and how she believes that this can happen. This would model the importance of her decisions as well as build trust. Does this woman want help with her mental health issues, or is she feeling pressured by outside sources to go and get help? Walking alongside the woman in her journey is the best support that any service provider can give.

Working with women who have mental health issues can be challenging and rewarding at the same time. It is important for the worker to assess their own comfort and abilities when working with women. A supportive team of colleagues and clinical supervision can allow the worker to feel comfortable with the ways in which she is assisting the client. Issues of mental health often are not presented in isolation. They can be connected to childhood abuse and trauma, violence and substance use. The woman may have been hurt by multiple perpetrators. Each woman will present her experience and story in different ways, as each situation is unique. Even within similar cultures, the experience of mental health issues and receiving supports will be different.

4.2.4 Barriers To Addressing Substance Use

Women in many cultures have been forbidden to consume alcohol and illicit drugs. The use of substance may have been considered a man's domain, and not something that a proper woman would engage in. As immigrant women are exposed to a culture in which they have choices about their lives, they are experimenting with many new lifestyles. As a result, many women have used drugs and alcohol recreationally, which can lead to using substances to numb emotional as well as physical pain. Combined with issues of mental health, this can be a frightening place for women to be. They often judge themselves in a very negative light, and are very ashamed for the choices they have made. It is often difficult for immigrant and refugee women to tell service providers about their struggles, as they feel they may be shunned further, because this type of behaviour is not expected of them. The stigma of mental health issues and misuse of drugs and alcohol, combined with violence and trauma, can create a challenging life for immigrant women. Service providers who are able to create an open space based on respect will be able to explore healthy choices in coping, which will allow the woman to share her most difficult problems and work towards healing.

Conclusion

As with all service provider and client relationships, creating safety, trust and a non-judgemental environment for immigrant and refugee woman will be the most effective way of allowing them to speak openly about their experiences with mental health and substance use issues. Women need to know that they will be heard and respected, and that the counsellor is there to support them through the counselling process. Some women will feel safer with workers from their own ethnicity, and others will feel comfortable with any worker that is empathetic and genuine. Being aware of the clients' needs and working with them in a respectful manner is the key to building trust and working together. As in mainstream culture, mental health and substance use issues still require a great deal of education and awareness, but each interaction with clients brings us one step closer to providing that much-needed support.

4.2.5 References, Resources And Further Reading

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4.3 Safety and Support for Women in Rural/Remote Communities

BY SARAH LEAVITT

Women in rural and remote communities who are facing violence and are using alcohol or drugs face many barriers when trying to access help. In this section we look at some of these barriers and offer suggestions for overcoming them.

4.3.1 Barriers To Safety For Women In Rural/Remote Communities

The BC Rural Women's Project produced a report in 2003 about some of the challenges facing rural women.

These include a lack of:

- Affordable housing
- Public transportation
- Support services
- Health services
- Educational opportunities
- Telephone and Internet access
- Government services

These are all services that are important for women who are seeking help for substance use, mental health and violence.

The following summary of some of the specific issues facing women in rural and remote communities who are experiencing violence could also apply to women with substance use or mental health issues.

Creativity, resourcefulness and participation from other community partners are often necessary to assist a woman in a rural community to increase her safety.

Confidentiality for Rural Women Who Have Experienced Violence

Prepared by Nancy Taylor, Stopping the Violence Counsellor, Robson Valley Home Support Society, McBride, BC

Maintaining confidentiality is vital when planning for safety with women living in rural, remote and farm communities.

Problems with maintaining confidentiality in rural communities:

- Many people have scanners capable of monitoring police radios.
- Even non-identifying information can reveal the identity of a woman and/or her children, i.e. when a woman from Highway 16 East with five children is the only woman in that area with five children!
- Roles that service providers fill may intersect with the roles women experiencing abuse fill, i.e. the children of a shelter worker may attend school with the children of a woman who is fleeing abuse.
- Extended family networks in rural communities share information between each other and tend to take sides.
- Women lack anonymity when accessing services in small communities. There is a fear that health care professionals and police will not maintain confidentiality.
- Gossip is a normalized form of communication in rural communities. There can be a perceived lack of confidentiality within service agencies when a women's story is discussed in the community.
- There is a general lack of anonymity in small communities. Women can be identified by the vehicles they drive, the routes they take, the people they associate with, etc. This can both threaten and enhance their safety.
- Safe Homes are located in private homes where it can be difficult to predict when other community members may drop by or call.
- Children staying in shelters are identified when riding on school buses.
- Safe Shelter Coordinators and Anti-Violence Workers become known in the community so assumptions about women accessing their services are easily made.
- Local 24-hour crisis line service is impossible in a small community because of lack of anonymity.
- Historical relations with families and workers can limit access to services.

Some dynamics of abuse in rural, remote and farm communities:

- Rural communities can be very different from each other so, although certain themes are common
- The problem has not been named; normalizing, minimizing and victim blaming are common.
- Intimidation tactics often include threats to harm pets or farm animals; farm women have witnessed the killing of animals so threats of femicide are very real.
- Firearms are readily available in farm and rural communities.
- Vehicles, farm machinery, power tools, etc. can be used to induce fear and terror.
- Farm women are often blamed for everything that goes wrong on the farm; crop failure, bad weather, animals getting sick, market and financial problems, etc.
- Difficulties in farming can be used as a justification for other abuses.

4.3.2 Ideas For Rural Safety Planning

Creativity, resourcefulness and participation from other community partners are often necessary to assist a woman in a rural community to increase her safety. These are some of the strategies that have been used by anti-violence workers to help women in rural communities:

- Set up "safe havens" in local businesses for women fleeing abuse. Recent projects in BC communities have resulted in a number of businesses volunteering to be places where victims of abuse can come for safety. Staff at the businesses are given information about which agencies to call or refer to, depending on the victim's wishes and the situation.
- Place an anti-violence worker in a doctor's office or the mobile library van to provide a less obvious place for women to seek help.
- Advocate for call boxes (direct lines to the police) on rural roads.
- Provide transportation to women to the safe house if there is no other transportation available.
- Create networks of family, friends and neighbours who are ready to help women in abusive relationships, or women struggling with substance use or mental health issues.
- Go to home visits in pairs to increase your own safety.
- Remind women to cover their tracks—offenders can often read foot prints and tire tracks in rural areas where there are dirt roads.
- Enlist the help of road maintenance crews to alert outreach workers or victim assistance workers when an offender's car is seen in a particular area. The woman is then alerted by anti-violence workers and given more time to get to safety.

4.3.3 References, Resources And Further Reading

BC Rural Women's Project: www.ruralwomenproject.bcwomen.bc.ca

Education Wife Assault: Rural and Farm Women: a fact sheet available: www.womanabuseprevention.com/html/rural_and_farm_women.html

Rural Women's Justice Guide: www.owjn.org/info/rural1.htm

Women's Rural Advocacy Programs: Problems of Rural Battered Women: a fact sheet available at www.letswrap.com/dvinfo/rural.htm

4.4 Working on Safety With Aboriginal Women on Reserve

Consultation for this section provided
BY MAGGIE MATILPI

4.4.1 Barriers To Safety

Many rural and remote communities are Aboriginal reserves or are located near reserves. Aboriginal women in these communities face additional particular barriers in terms of accessing services and maintaining safety.

In the summer of 2007, the provincial government held a series of “conversations on health” with Aboriginal people. When participants were asked about the important health issues for Aboriginal communities, there was a significant focus on substance use and mental health issues. Concerns included:

- Lack of access to health care specialists
- Lack of culturally appropriate services
- Short term funding only for programs such as tobacco cessation without any follow-up support
- Lack of trained medical and counselling staff to provide appropriate diagnoses, prescriptions, emotional support and long term follow-up and support
- Lack of follow-up in the community for people who have gone away to detox/treatment and returned
- Misdiagnosis of the effects of residential school—e.g. schizophrenia instead of post traumatic stress disorder
- Lack of services for children and youth who are using substances
- High rates of suicide and attempted suicide and lack of community supports and communication among services and bands—lack of discharge planning after hospitalization for a suicide attempt
- Overprescribing of psychotropic medications to elders; abuse of prescribed medications.

Anti-violence workers consulted for this section identified further barriers:

Lack Of Anonymity Or Confidentiality

- Her abuser’s family may have a lot of power in band governance or in services such as mental health and may deny her services.
- She may have already experienced a lot of negative judgment from others in her community, which may prevent her from reaching out for service.

The Impact Of Intergenerational Trauma

The history of colonization in Canada, particularly residential schools, has had a severe impact on Aboriginal people. Most Aboriginal communities suffer from high rates of violence and substance use. People are often suffering from high levels of trauma and there may be a strong culture of addiction. Within this context, it can be extremely difficult for women to escape violence or recover from addiction.

- Violence may be generally accepted; women may be blamed for the violence they experience.
- Women may feel hopeless and trapped when they consider making changes.
- There may be little encouragement for people to stop using drugs or alcohol.
- The effects of drug or alcohol use, or the impact of FASD, may make it difficult for women to plan or make changes.

■ Intergenerational trauma or multi-generational trauma happens when the effects of trauma are not resolved in one generation. When trauma is ignored and there is no support for dealing with it, the trauma will be passed from one generation to the next. What we learn to see as "normal", when we are children, we pass on to our own children.... The unhealthy ways of behaving that people use to protect themselves can be passed on to children without them even knowing they are doing so. This is the legacy of physical and sexual abuse in residential schools." (Aboriginal Healing Foundation 1999)

The long history of Aboriginal children being removed from their homes has had a huge impact on communities. This legacy prevents some Aboriginal women from reporting violence or seeking help for substance use for fear of losing their children.

Colonization and racism have also led to a high level of poverty among Aboriginal people, which creates another strong barrier to escaping violence and addiction.

Consequences Of The Indian Act

The Indian Act became law in 1876. There have been many significant changes to the Act since that time, particularly changes in the mid-1980s to the definition of status. For example, before these changes, an Aboriginal woman would lose her status under the Indian Act if she married a non-Aboriginal man. Bill C-31 restored status to these women as well as others who had lost their status.

The Act governs many aspects of how the federal Canadian government deals with Aboriginal people. It affects taxation, housing, land rights, etc. Many parts of the Act only apply to Aboriginal people living on reserve. There are many implications of the Act, which cannot all be addressed here. The Act has been widely criticized by Aboriginal people.

Individual Aboriginal communities have some ability to determine how they will deal with certain rights under the Indian Act. For example, under the Act, members of a band have the right to housing on their reserve. If a woman from outside of a particular band marries a band member, she no longer has rights to housing in that community if she leaves him. However, the band may decide that she can stay on the reserve if she has custody of the children and the children are band members. Different bands will also have different policies about how to determine membership in the band. It is important to be familiar with the basic elements of the Act and especially how the community you work with has chosen to address issues such as the right to housing. (See Resources section for sources of more information)

Services Provided By The Band Versus Other Anti-Violence Services

Aboriginal women dealing with violence may use services provided by their band instead of services such as STV Counselling or Outreach programs or CBVAP. The band services are usually not women-centred but may be more culturally based, incorporating healing practices such as sweats and smudging. Many women benefit from traditional healing practices, but they may suffer from a lack of attention to safety particularly when services are not gender specific. On the other hand, they may not feel welcomed or accepted at non-Aboriginal services. And if they are, the services may be difficult to get to (only available on occasional basis, confidentiality is compromised as the entire community knows what day the service provider comes on reserve or requires travel to access), or not culturally sensitive.

Lack Of Resources For Youth

Many reserves have a high proportion of young people. However, there are few recreational resources and a high level of unemployment, leaving many youth with extra time and a lack of activities to fill it with. This context, combined with the emotional impact of trauma, inter-generational abuse and colonization, can lead to an atmosphere of partying and substance use, in which women are vulnerable to sexual assault and unplanned pregnancy. Activists suggest that increased options for support and recreation for youth could help address this situation.

4.4.2 Suggestions for Providing Support and Safety Planning

Acknowledging The Impact Of Colonization

An important part of supporting women who have experienced violence is putting their experience in context (see Trauma, Mental Health and Substance Use within an Anti-Oppression Perspective for more information).

- Educate yourself about the impact of colonization and the Indian Act, the current state of Aboriginal peoples in Canada, and the history of the particular community you are working with (see end of this section for Resources that will help you).
- Check out how much information the woman has about these issues; explore (following her lead) the history of her own family and community. Help her make links between her own experience and the larger context.
- Be aware of and share with her some positive achievements by Aboriginal people—for example, the activism by Aboriginal women that led to the passing of Bill C-31 (which restored Aboriginal women's rights). Celebrate the strength and survival of Aboriginal people.

Addressing Mistrust Of Systems

- Many Aboriginal women may fear working with systems because of previous negative experiences of racism, including stereotyping, blaming, child apprehension, misdiagnosis, etc. Validate the reasons for women's fears and explore ways to address them.
- Women may be reluctant to sign documents such as Consent to Release Information forms because of the history of systemic abuses including forced removal of children. Suggestions for dealing with this include:
 - Document verbal consent and leave written consent for when more trust has been established, if possible.
 - Go over documents in detail to be sure she understands them (low literacy levels may also be an issue).
 - Ask if she has a trusted friend or family member who could review documents and witness her signature.
 - On release of information forms, provide a place where she can sign to revoke consent and make it clear that she has the right to do this.
- Some women have difficulty accessing services because their abuser's family has a great deal of power in the band council or in services such as mental health. Women may be denied service or may simply choose not to access services at all because of their fear of what the consequences might be. One strategy that might help is to see if there are workers within the services who are open to working with the woman and who would be willing to come to her home (or a central, less identifiable location such as a health centre) so that she does not have to go to the band office or an office identifiable as an anti-violence service.
- Many Aboriginal women want help for their abusive partners and will not phone helpers or police because they believe the justice system discriminates against Aboriginal men. As an anti-violence worker it is important to acknowledge the historic and current systemic biases that Aboriginal peoples face particularly within the criminal justice system while reminding a woman about her rights and working towards safety.

Getting Support From Band Council

- A woman may be reluctant to leave an abusive relationship because she could lose custody of her children. Seek assistance from her band to get letters of support and set up a safety plan for her children. In the instance of child welfare on reserves, a letter from a band is valuable.

Planning For Safety With Substance Use

- Ask her what her preference is to stay safe when she's under the influence of alcohol or drugs: start her safety plan with phone numbers of her preferred support network, band name and number, etc.
- Identify safe places for her to go when under the influence.
- Identify safe places for her children to stay when she is intoxicated.
- Plan for safety if her suicidal feelings tend to increase with substance use or withdrawal.
- Discuss how you will respond and follow up if she contacts you when under the influence. This is an important thing to discuss; the goal is to reduce the shame that women often feel after contacting a support worker while drunk or high. Remind her that you are there to support her.
- Familiarize yourself with detox and supportive recovery policies. There are services available off reserve for women who wish to leave the community for these services. Mental Health and Addictions Services provide workers who do assessments and referrals for beds. Services are limited in remote communities and the availability of travel subsidies depends on the individual community budget. Health Canada does not provide transportation to non-medical appointments. If your client is referred to a specialist, this will provide travel funds, so use it as an opportunity for her to get ex parte orders or attend other helper appointments: therapists, lawyers, interview for housing, establishing a separate bank account, seeking addictions counselling, leaving the relationship, etc.
- Bands will provide travel for their members to attend treatment, but band funding for Aboriginal women is always for an Aboriginal specific program. This is not always appropriate for the woman. Many women would be better served by a gender specific program such as Aurora in Vancouver, but will need advocacy to try to get travel subsidies to attend.

Planning For Safety In Cases Of Violence

- If there is no formal safe house or transition home in the community, seek a safe house for the time of crisis. Even when there is a transition home, some women will not feel safe to go there because the location is widely known or because they know some of the workers and worry about confidentiality or judgement.
- Workers might consider approaching property owners to establish a protocol for quick easy rentals with furnishings for women escaping violence.

Working With Child Custody Issues

- Most women report that they prefer not to work with MCFD because "they don't trust them". There are many reasons for this. For example, some women have signed voluntary care agreements for their children during or after leaving an abusive relationship. However, they are then told that the children will not be returned until the mother has demonstrated long-term sobriety. Some women may go back to their addiction, as this is another trauma/stressor on top of leaving a harmful situation. Women may want to sign an agreement to have their children stay in the home of a relative instead.
- Band welfare workers and counsellors are often very poorly paid and overworked. Often the band workers don't have a good understanding of women's safety issues. Women may be concerned that their children are unsafe in their current situation, but may also be afraid to seek help for their children, for fear that they will be removed. There are few foster homes, and if child welfare wants to place kids under kith and kin agreements with family members, there are not always healthy family members available. Some women do not want to connect with their band for services, as there is the perception that there isn't confidentiality and there are biases based on who is related to whom.

4.4.3 References, Resources And Further Reading

For more information on the Indian Act, go to the Justice Canada website: <http://lois.justice.gc.ca/en/showtdm/cs/l-5>.

For more information about intergenerational trauma go to the Aboriginal Healing Foundation website: <http://www.ahf.ca>

Aboriginal Healing Foundation. 1999. *Aboriginal Healing Foundation Program Handbook*, 2nd Edition. Ottawa: Aboriginal Healing Foundation.

For a discussion of links between colonization and racism and violence in Aboriginal communities, see Emma D. LaRocque. 1994 *Violence in Aboriginal Communities*. Ottawa: Health Canada 73–76.

Aboriginal Trauma Treatment Centres

Tsow–Tun le-lum Society in Lantzville, BC provides a three-week residential trauma recovery program. Participants must have three months clean time. See www.tsowtunlelum.org.

The First Nations House of Healing on Quadra Island provides gender-specific programs from nine days to three weeks long. Provide services free of charge if the client is registered under the Indian Act, which includes treatment services and a travel subsidy. Each program will create awareness of the legacy of residential school and its impacts to former students and their families. This will include addressing anger, healthy identity, living empowered, cultural and spiritual reconnection, communication skills, boundaries, self-care and healthy relationships. For more information see www.intertribalhealth.ca or email fnhh@intertribalhealth.ca or call 1-877-777-4842 for current programming.

Indian Residential School Survivors Society (IRSSS) provides support and general information regarding common experience settlement and support for residential school survivors and their families. Also provides assessment for counselling services for survivors and their children at the closest resource to the survivor's community. See www.irsss.ca.

Addiction Services

Association of BC First Nations Treatment Programs: Provides practical information about residential treatment centres in BC for First Nations people, but is not restricted to First Nations people. www.firstnationstreatment.org

Vancouver Island Health Authority: Information about mental health and addiction services. www.viha.ca/mhas/resources.htm#links

First Nations and Inuit Health Branch (FNIHB): Information regarding Non-Insured Health benefits such as travel and payment for residential treatment services and for short term crisis counselling. www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnib-dgspni/index_e.html

4.5 The Importance of Identity In Working With Métis Women

BY BELINDA LACOMBE

4.5.1 Introduction

Terminology is important when working with a person who is a blend or a fusion of two cultures. As a Métis woman myself I understand the significance of my Métis label as one of pride and strength. Unfortunately, this is not the case for many of the Métis women who enter an anti-violence agency. They may have all sorts of negative preconceived notions of what it means to be Métis. They may not even recognize themselves as Métis.

4.5.2 Identity And Women

Women who can be called Métis can feel particularly vulnerable when they enter the office of an anti-violence worker. Their degree of vulnerability hinges on their acceptance of both parents' ancestry. Unfortunately, what I have seen more times than not is a denial of the Aboriginal side of themselves. There are many reasons for this: the Aboriginal parent might have terrible experiences with residential schools, racism and discrimination and therefore wants to protect their child from these experiences. They protect by keeping their ancestry a secret or creating a deep sense of shame by over-identifying with their white partner's family. In many Métis families the children who the Indian agent saw as Aboriginal were taken to residential schools and those children who were fair-skinned were allowed to stay with their parents. This has long-term repercussions.

Métis women may have learned that to acknowledge the Aboriginal side of who they are makes them less in the eyes of society or more likely to be discriminated against or victimized. They may have been told that Aboriginal people are all "drunks and bums" and believe these things. Essentially, they may carry a sense of hatred for a piece of themselves and worse yet, a very big secret. The problem with this denial of self is the unwillingness to look at the family history with the Indian Act, the unwillingness to share the family secret and most importantly the lack of a full self. The implication for trauma work with these women is that they cannot truly heal from trauma if they are caught up in secret keeping, denial of identity and shame around identity. This means that our work with them has to begin with creating safety so that identity can be addressed. Without this time consuming work, real healing may not occur.

The cultural genogram¹ is an excellent vehicle when working with women who believe they may be Métis. It provides an opportunity to ask them about family practices and where they think they originate. For example, a woman I worked with revealed during a session in which we were using a cultural genogram, that a distant relative told her that her abuse was due to the fact that her father (the abuser) was abused in a residential school for most of his young life, and was therefore really not accountable. Her relative tried to convince her that it would be best if she simply forgot about what happened to her and moved on with her life. Nobody,

¹ A cultural genogram is an adaptation of a family genogram that promotes exploration of cultural influences on an individual's family experience. See Hardy, K.V. and Laszloffy, T.A. 1995. The Cultural Genogram: Key to Training Culturally Competent Family Therapists. *Journal of Marital and Family Therapy*. 21(3): 227-37 for more information.

not even her mother, knew about her father's childhood experiences, and if she were to start digging around, the family's past would be revealed and with it this family's secret.

For many women who have been denied their Métis culture, simply learning about the history of Métis people and what a distinct and proud people they are can be very empowering. Their learning can help them explain some of the questions they have about their upbringing. For example, for the above mentioned woman, as she learned more about Métis culture she understood why her Dad was not interested in community involvement and socializing. He had no experience with the larger community because he grew up in a Métis family that was "its own community." He was not trying to deny her friends; he simply did not understand her need for outside involvement. Although he did not acknowledge his Métis self he continued to live a Métis way of life. This can be very confusing for a child. She always thought he was simply mean and did not care if she had any friends. This was very an important learning for her and it made her want to know more.

Fortunately, as anti-violence workers we have an opportunity to facilitate a positive image of Métis women. Bring examples of Métis women into your conversations with your client. Invite Métis women to talk in women's groups. They understand this unspoken invisibility. These things can be immensely powerful for Métis women who are beginning to connect to their identity.

4.5.3 References, Resources And Further Reading

Brown, J. 1983. Woman as Centre and Symbol in the Emergence of Métis Communities. *The Canadian Journal of Native Studies* 3: 1: 39-46.

Campbell, M. 1973. *Half Breed*. Lincoln: University of Nebraska Press.

Carpenter, J. 1977. *Fifty Dollar Bride: Mary Rose Smith A Chronicle of Métis Life in the 19th Century*. Sidney: Gray's Publishing.

Culleton, B. 1983. *In Search of April Raintree*. Winnipeg: Pemmican Publications.

MacEwan, G. 1981. *Métis Makers of History*. Saskatoon: Western Producer Prairie Books.

Métis National Council of Women: www.métiswomen.ca

Turtle Island Productions: www.turtle-island.com

Van Kirk, S. 1983. What if Mama is an Indian: The Cultural Ambivalence of the Alexander Ross Family. In L H Thomas and J E Foster, eds. *The Developing West*. University of Alberta Press.

4.6 Safety Planning with Sex Workers

4.6.1 Introduction

Women who are sex workers are highly vulnerable to experiencing violence in their lives. Many live in a world of exploitation, judgment and stigma, and face multiple barriers to accessing support and health services. Their lives are often compounded by a number of factors, including poverty, homelessness, trauma (PTSD), substance use, racism, disability and having their children apprehended. As a result, survival sex workers are among the most marginalized and vulnerable population of women you may work with.

Survival sex workers also have incredible strength and courage in facing and enduring the conditions that brought them into the work and that continue to impact on their lives. Survival sex workers often face complex risks to their safety and struggle to trust when they have been offered little or no protection in the past. Establishing a trusting relationship is crucial but is likely to take time. Many survival sex workers have incredibly highly tuned safety strategies, so be sure to take their lead when discussing safety planning. In this section we have included specific information on sex work relevant to anti-violence work. We have also included a set of safety planning guidelines.

4.6.2 General Information On Sex Work

The following information is adapted from the *Network of Sex Work Projects Promoting Health and Human Rights*: www.nswp.org/nswp/introduction.html.

Background On Sex Work

Commercial sex takes place in many kinds of ways and involves many different types of people, many of whom are in no way stereotypical. People of various backgrounds sell sex and they do so for a broad range of reasons. These reasons often change over time. Some people sell sex as a full-time occupation, while others sell sex occasionally. Some people are willing sex workers and others are pressured to sell sex and others are sold for the purposes of selling sex. Commercial sex is an ancient and widespread phenomenon. Women, men and transgendered people sell sex all over the world and have done so forever. It is more useful to think about sex work as the sale of services and time rather than selling one's body.

There are plenty of reasons why people sell sex, the main reason being that people need to "make ends meet." Few people to whom all other options are open choose sex work. Most people choose sex work out of a limited range of choices. For some, sex work brings autonomy from oppressive families or partners or occupations. For others, sex work offers an escape from poverty or a way to secure material stability and privacy. For a very few it is the fulfillment of a fantasy or of a natural talent. For others it may simply be a question of chance. Not all or even most people who face pressure, poverty and very limited options become sex workers.

One of the most popular questions about sex work is “Why do people sell sex?” The obvious answer is “Because people buy sex.” The sex industry is subject to the same economic rules as any other business or industry—demand drives supply. However, the factors that create demand for commercial sex reflect multiple realities. Clients seek sex workers for a variety of reasons. Some clients seek sexual services because they want to have sexual relations without emotional ties, or because they like the thrill of anonymous sex. Some like illicit or forbidden sex, because they want to perform sexual acts that their sexual partner does not approve of or cannot perform, or to fulfill sexual fantasies. Some look for the illusion of being loved by someone, others to prove their masculinity or power over someone else. Many clients seek sex workers to learn about sex, while others look for someone to talk to and keep them company. On the other hand, some perceive a commercial sexual transaction as the purchase of a body to which they can do whatever they like. Some think that by purchasing a sexual service, they also purchase the sex worker's right to say no.

Third Parties

Many other people are involved in commercial sex in addition to the sex workers and clients. These include business owners, bar tenders, cleaners, taxi drivers, maids, receptionists, touts, security staff, local vendors and many others. The people with whom sex workers share their private lives may also have a role in influencing the environment in which sex workers live and work. Note that the term “pimp” is not used in this section. It is unhelpful because it collapses too many of the “third parties” described above into one [stigmatized] category. This reduces the opportunity to understand the important and different influences that these actors may have. Most sex workers rely on the support of third parties in their work. Many third parties are crucial to the protection and safety of sex workers and to the provision of sex work itself. However, some third parties can and do exploit sex workers.

A good brothel owner is one who provides good working conditions and pay, just like any other good employers. There is nothing inherently exploitative about commercial sex, but its status and sex workers' lack of civil and industrial rights offer few mechanisms to limit the behaviour of bad employers. Relationships vary greatly between sex workers, their employers and other third parties, including even those defined as “traffickers”. Slavery is at one end of the continuum and very good business arrangements are at the other.

Sex workers' personal relationships with family, friends, lovers and husbands also vary greatly. Some sex workers are forced to enter or remain in the industry by people with whom they have personal relationships, and others enjoy supportive relationships that can have a crucial role in their well being and safety. Sex workers' private sexual partners also affect sex workers' health. In places where most commercial sex is protected or non-penetrative, high sexually transmitted infection rates among sex workers have been attributed to their private sexual partners.

Local gangs and criminal groups often play a part of the sex industry. This can but does not necessarily lead to exploitation. They may provide protection from police and violence and provide other services that sex workers value. Stereotypes, simple labels and moralistic analyses can obscure the multiple realities within sex work.

Police

The relationship between sex workers and the police is varied. In some cases, police harass sex workers. Police can be the main source of violence towards sex workers. Some police officers extort money from sex workers in exchange for not arresting them. Police are also a major client group, and therefore engage in all types of client-sex worker relations. On the other hand, in many cases the police have an understanding of commercial sex and protect sex workers from criminal elements. Sometimes the police tolerate sex workers or commercial sex establishments in return for some information from sex workers about local criminals.

Sex workers, like other marginalized groups, are often reluctant to report assault to the police. Women in the sex trade may be reluctant to report because of:

- Perception by the public that assault is part of the risk of their lifestyle
- Their own, or others', negative experiences with police
- Mistrust of the system, a belief that the system will not respond
- Fear that they will not be believed
- Fear that they will be arrested if they have outstanding warrants
- Fear of retaliation by the assailant

At the same time, sex workers are far more vulnerable to physical and sexual assault than the general population. Recent cases involving Donald Bakker and Robert William Pickton have highlighted the incredible risks that sex workers face.

Some municipal police and RCMP detachments in BC, particularly in urban centres, have made efforts to build relationships of trust with sex workers. In 2007, the BC Association of Chiefs of Police accepted a proposal for implementing third party reporting procedures across the province. Third party reporting allows a victim of sexual assault to make a report to a third party, such as an anti-violence agency, who then passes that report on to police. Third party reports can be especially beneficial for sex workers, because of the considerations listed above. (The proposal was developed by the Community Coordination for Women's Safety Program; for more information see *Third Party Reporting: Access to the Criminal Justice System for Marginalized Victims of Sexual Assault* Available at www.endingviolence.org.)

Forms Of Sex Work

There are many types of sex work. Once again, diversity is the rule. Some sex workers look for quick transactions while others look for long-term clients. In some cases, sex work and domestic work are combined. There are reports of women who work as both maids and sex workers in the Middle East, as homes offer a good cover for illicit activities. Police do not usually enter homes and outsiders never enter without being invited. Similarly, sailors and truck drivers in some African locations typically hire a woman's services for a few days. Services include washing clothes, cooking, general domestic tasks and sexual services. In this scenario, sex is not a central part of the agreement.

There are specialized types of sex work. Some sex workers offer specialized services such as sado-masochism, domination and submission. These specialized services rely on role-playing and the fulfillment of fantasies and fetishes. They do not necessarily involve any sort of penetrative sex. Some sex workers specialize in providing sexual services to people with disabilities. They are called surrogates and their work is a mix of sex work and sex therapy. These services involve specialized knowledge of safe practices and techniques.

Some people practice sex work in an indirect form. They may be entertainment workers (strip-tease dancers, belly dancers, go-go dancers, karaoke singers) who may engage in sexual transactions occasionally. Such transactions do not necessarily involve purely sex or penetrative sex. There is a whole range of sexual activities that differ greatly from straightforward sex.

Workplaces And Safety

Different sex work venues include streets, brothels, bars, saunas, massage parlours and other settings. Male sex workers also operate in resorts, gay bars and clubs, cinemas, car parks and cruising areas for gay men like parks, swimming pools, and public toilets.

Sex workers' safety in the workplace is determined by a variety of factors. These include quality of lighting, the presence of support staff or other sex workers, clean facilities, access to water, safe sex equipment and accessories such as water-based lubricants.

The relationship between being a resource-rich sex worker and safety and being a poor, low-priced sex worker and safety is complex. An escort who sees her clients in a five-star hotel is not necessarily safer than a brothel worker, as she is more vulnerable to violence from clients due to her physical isolation. However, an escort working in that setting has more negotiating power with her client as she is accorded more status in the industry overall and often clients are interested in being repeat clients. Women who work in relatively low paid sex work in truck stop bars have some safety, because there are many other sex workers around, they are on their own territory, and bar tenders offer security to some extent. Survival sex workers, however, may be particularly unsafe as they most often work in very isolated areas (industrial zones, dimly lit areas, on the street) and most often are working completely alone. Survival sex work has become increasingly competitive as women's economic safety nets deteriorate, resulting in less cohesion among workers and more isolation in the work. In addition, a survival sex worker has the least negotiating power with a client and may be sought out as a target for violence.

Avoiding violence is often an important consideration for sex workers when they steer men towards different places to have sex and different sex acts and positions. More experienced sex workers often share stories and tips about which types of sex minimize the risk of violence in particular settings. For example, sitting on top of the man during sex gives more control than being under him. Scarves, "pony tails" and jewellery that can be used to trap or strangle a sex worker should be avoided. If a man is drunk, it is to the sex worker's advantage to have calming strategies.

4.6.3 Safety Planning Guidelines

The guidance below is focused on safety when undertaking sex work and has been taken from <http://www.livingincommunity.ca/toolkit/ASWpage2.html> with some minor adaptations and changes.

General Tips To Keep Us Safe

- Try not to work when you are high or drunk as you may be more vulnerable to abuse or not be able to respond as quickly to an escalating situation.
- Wear shoes in which you can run, or that you can slip off easily.
- Do not wear anything around your neck that a client can use to strangle or drag you such as necklaces, scarves, etc.
- If possible carry a cell phone. You can call yourself and leave a message with a description or text the license plate to a friend. Even if it does not work or is out of minutes, carry it with you in plain view, as a client may be less likely to take a chance.
- Work with friends if possible. If you have to work alone, be creative and carry a piece of chalk with you to write down the license plate of your next client on the sidewalk or wall where you are standing. Always casually tell a client you have been seen leaving in their car and are expected back at a certain time.

- Carry a whistle. Some prefer to carry devices that can be used to protect themselves such as mace. However, it has been proven that such things can be turned against you at any given time. A whistle is safe, small, compact, legal and loud.
- Be extremely careful on the street.

Observe The Client

- Listen to his voice and observe body language.
- Listen to your intuition—if it does not feel right, there is a good chance it is not.
- Are they high? Are they drunk? Are you prepared to deal with them? Always ask yourself these questions.

Entering A Client's Vehicle

- Make sure the client is alone. More than one person increases your risks.
- Do a full circle around the car. Get the license plate number.
- Check behind the back seat to make sure that no one is hiding.
- Always check door handles before you get in to make sure they work.
- Make sure you know how to unlock the door before entering car.
- Try to avoid vans, pickups, and SUVs, especially with tinted windows.

Going Somewhere

- Unless it is a regular, avoid bridges, tunnels and dimly lit unfamiliar places.
- Pick your own parking spots and hotels.
- Check the address. If the client says they are taking you to one place, but pulls up to another, this may not be all they are lying about.
- Do not enter a room if there is more than one person. If others show up, leave immediately.
- When in a car or in a room, keep an eye on the exit at all times and do not let the customer block your access to it.
- It is safer for you to bring a client to your house and hide a friend in the closet than it is for you to go to the client's house and have his friend hiding in the closet.

4.6.4 References, Resources And Further Reading

Community Coordination for Women's Safety. 2007. *Third Party Reporting: Access to the Justice System for Marginalized Victims of Sexual Assault*. Available at www.endingviolence.org.

The *Community Initiative for Health and Safety* (CIHS) is derived from the two-year Living in Community Project that was conducted in Vancouver, BC. This project is a collaboration of community and government organizations, including peer-based groups formed by current and former sex workers (otherwise known as prostitutes or hookers), neighbourhood houses, community policing centers, business improvement associations, the City of Vancouver, Vancouver Police Department, Vancouver Coastal Health and the Vancouver Agreement.

CIHS website at <http://www.livingincommunity.ca/toolkit/ASWpage2.html>.

Please note: This website includes a list of organizations that support sex workers.

Farley, M. 2003. *Prostitution, trafficking and traumatic stress*. New York: The Haworth Press, Inc.

Network of Sex Work Projects Promoting Health and Human Rights. www.nswp.org/nswp/introduction.html.

4.7 Working With Women With FASD: An Emphasis on Safety Planning

BY TESSA PARKES

In compiling this resource we were not able to find specific materials on *safety planning* with women with FASD. Indeed, there is very little research, literature or practical guidance that deals with women with FASD specifically, or includes a gendered perspective. There are, however, a number of sources that outline strategies to consider when supporting adults with FASD. This information can be applied and adapted to working with individual women who use our anti-violence services.

4.7.1 What Is Fetal Alcohol Spectrum Disorder?

FASD is an umbrella term used to describe a continuum of effects that result from maternal alcohol use during pregnancy. FASD is a brain-based physical disability with behavioural symptoms, and affects people in different ways. . Many of the disabilities associated with FASD are hard to discern by others, particularly those that do not know the person, such as problems with memory, reasoning and judgment. For many affected people there can be a problem with lack of social boundaries and difficulty in reading social cues and understanding the link between actions and consequences. Unlike other better understood disabilities affecting the brain, such as Down Syndrome, FASD is often invisible. It may seem that a person with FASD is being uncooperative, resistant, non-compliant or unmotivated, when they just do not understand what they are supposed to be doing. They may be talkative, sociable and engaging, leading others to assume they can manage their lives the same as a person without this disability. Another key reason why people with FASD are often viewed as uncooperative or lazy is because of their difficulties with receptive communication. That is, they may be able to speak well but have difficulties understanding. This creates additional social vulnerability.

Definitions

Many terms have been used to describe abnormalities that can be associated with prenatal exposure to alcohol. Fetal Alcohol Spectrum Disorder (FASD) is a non-diagnostic term that covers the full range of birth defects and disabilities associated with prenatal alcohol exposure. Since 1996, the following four diagnostic terms have been accepted.

1. Fetal Alcohol Syndrome (FAS)

There are three criteria used to describe the effects of prenatal alcohol exposure in order to make a diagnosis of FAS: a pattern of facial abnormalities (may include unusually small eyes, smooth upper lip, etc; see resources below for more information), growth deficiencies and central nervous system impairment. The central nervous system impairment many include structural abnormalities of the brain; neurological problems such as impaired motor skills, poor coordination and visual problems; and behavioural and/or cognitive problems such as mental handicap, learning difficulties, poor impulse control, problems in social perception, problems with receptive communication, and problems in memory, attention, reasoning and judgment.

2. Partial FAS (PFAS)

Partial FAS is the term used to describe those individuals born with evidence of some of the characteristic facial abnormalities associated with FAS and evidence of one other component (growth deficiency or central nervous system impairment) when it is known that there was significant prenatal exposure.

3. Alcohol Related Neurodevelopmental Disorder (ARND)

Alcohol Related Neurodevelopmental disorder describes the presence of the structural or neurological brain abnormalities and/or the behavioural and cognitive problems associated with FAS, without the characteristic facial or growth abnormalities, when it is known that there was significant prenatal exposure.

4. Alcohol Related Birth Defects (ARBD)

Individuals born to mothers who drank heavily in pregnancy may also have congenital birth defects such as skeletal abnormalities, heart defects, cleft palate and other craniofacial abnormalities, kidney and other internal organ problems and vision and hearing problems. These are known as Alcohol-Related Birth Defects (from Poole and Loock 2005).

4.7.2 Challenges That A Woman With FASD May Have To Deal With

The primary disabilities associated with the diagnosis of FASD come under the area of cognitive processing. The impact these cognitive processing problems have on an individual's life tend to be most noticeable in the following areas:

Difficulty with:

- Understanding cause and effect
- Understanding consequences of actions
- **Learning**—the ability to learn can be compromised so that even simple tasks can need constant repetition over a sustained length of time.
- **Generalization**—taking information from one situation and applying it to another.
- **Decision making and judgment**—relatively simple decision-making and judgment tasks can be overwhelming for individuals who have problems with organization, working memory, sequencing, abstract thought, goal directed behaviour, field-dependency and impulse control.
- **Communication**—receptive and expressive language skills can be compromised—content of speech may be confused and not to the point—receptive language is often particularly compromised.
- **Information Processing**—may fluctuate from day to day and within a given day, due to familiarity with specific information, competing demands, structure of the environment, emotional state of the individual and/or degree of fatigue.
- **Emotional Regulation**—a person may go from being calm to agitated without an apparent explanation. This can be combined with poor inhibition and confusion in the interpretation of incoming sensations. Individuals can be easily overwhelmed by relatively commonplace events/circumstances and react to everyday situations with emotional volatility.
- Managing money
- Paying attention, staying still and perseverance.

Disabilities associated with FASD come under
the area of cognitive processing.

If you are working with a woman you think may have cognitive or developmental challenges, you may want to consider the possibility that her struggles are connected to FASD. Here is a list of “ways of being” commonly shared by people with FASD:

Memory

- Memory may skip from day to day.
- May need to hear something many times before it can be remembered— if ever.

Decisions

- Thinks in black and white—doesn't understand grey.
- May have trouble making decisions and understanding outcomes of those decisions.
- May have difficulty understanding responsibility and taking responsibility for their actions.

People skills

- May have trouble reading other people's signals or body language.
- May have difficulty making judgments about other people, particularly difficulties recognizing or predicting when people may be taking advantage of them.
- May have different boundaries than others:
- May take things that don't belong to them without viewing it as stealing
- May touch others in a way that is crossing boundaries.

Time and place

- May become upset when routines are changed.
- May have trouble understanding “yesterday” and “tomorrow” or “before” and “after.”

Communication

- May talk a lot but say little—their talk may sound like they are understanding you, but often they will not.
- May take things literally and not understand the double meaning of some words.

As a result of all the dimensions mentioned above, plus impulsivity and difficulties in controlling anger, women who live with FASD are at far greater risk of experiencing violence, trauma, mental health and substance use problems than women without these disabilities.

Obviously some of the points listed above have critically important implications for women living in violent relationships and for safety planning, which will be addressed later in this section.

Challenges with goal directed behaviour, organizational ability, literacy skills, and communication can make everyday living overwhelming.

4.7.3 Guidance On Supporting A Woman With FASD

Most adults with FASD are not diagnosed: a diagnosis is often difficult to make in adulthood. If you work with a woman who is having difficulties in the areas that have been described above, you could think about using some of the strategies outlined below, whether the woman has been assessed as having FASD or not. However, when using these strategies please keep in mind that a woman with FASD cannot change her disability. The strategies that are outlined below are designed to sensitize us to many of the potential difficulties a woman may have and what may help if we are able to adapt *our* ways of working to better suit her needs.

There is literature that describes the importance of people with FASD being connected with someone who can act as their “external brain” (Buxton 2004). A person who provides support as an external brain, or “external hard drive,” is someone who assists in a friendly and nurturing way, providing help in the form of cues to support the person with many aspects of their life. These cues can be things like verbal reminders, help constructing lists and, if necessary, help in creating an environment with structure and boundaries. The types and amount of external brain support will be dependent on the particular needs of the individual.

Work by Sharon Hume and Associates (2006) indicates, however, that when external supports are withdrawn, it is unlikely that the person with FASD will be able to maintain the activities or behaviour that they were able to do when the supports were in place. This work evaluated a project that provided one-to-one support to women and girls with FASD to improve their self-esteem and build on their strengths in order to increase their safety. While the evaluation found that some participants had improved personal safety, it also found that without ongoing support the women could not carry on with the activities, leaving them vulnerable to further risks. *The researchers concluded that “environmental accommodations and routines established with the assistance of others need to be reinforced on an ongoing basis: reminders, accompaniment, transportation, and modeling of appropriate social skills are examples of useful environmental accommodations.”*

For workers in the anti-violence field, it may well not be possible to work with a woman over a long period of time providing this level of support and guidance. We must therefore try to do what we can, in the time we do have, to help a woman to create a wider support network for herself that is made up of positive and safe others who can help on a longer-term basis. She may already have this, but if she is in a violent relationship the chances are that she will not have such a support network.

Many of the disabilities associated with FASD are hard to discern by others, particularly those that do not know the person, such as problems with memory, reasoning and judgment.

4.7.4 Strategies To Use When Working With Women With FASD

The table below identifies some challenges a woman with FASD may have and ideas you could try in your role as advocate and counsellor. Remember: many of the strategies listed will only really be effective when used on a 24-hour basis. Our purpose in listing them here is to help you think creatively about a woman's potential support needs and ways of changing your ways of working to make them more inclusive and appropriate.

CARES: The Basics Of Working With Someone Affected With FASD

CUES	<ul style="list-style-type: none"> • Use visual and voice cues • Give simple, clear and concrete instruction • Avoid list of steps that may be difficult to remember, give no more than one step at a time, and only when the individual is about to undertake the activity (may be impossible if your work with a woman is office based) • Focus on what is happening now • Help with transition
ATTITUDE	<ul style="list-style-type: none"> • Try differently not harder • Drop your own assumptions and get curious • Look for strengths • Check your goals and expectations as you learn more about this person • Work within your agency to develop and implement a consistent care plan. Discuss and document results with your work team and with your client
REPETITION	<ul style="list-style-type: none"> • Repeat yourself using the same words each time • Probe for understanding—have them show how they understand what you've said • Keep mood calm and distraction levels as low as possible • Provide reminder tools and aids as needed • Keep consistent
ENVIRONMENT	<ul style="list-style-type: none"> • Keep safe spots where someone can go to calm down • Create special evacuation and safety procedures (alarms can be over-stimulating) • Help community members to understand
STRUCTURE AND SUPERVISION	<ul style="list-style-type: none"> • Be consistent • Limit choices and the need for decision-making • Keep to routines as much as possible • Give immediate feedback

Adapted from the *We Cares* resource kit by Anne Wright and Associates (2004).

4.7.5 Safety Planning With Women With FASD

Safety planning requires cognitive processing skills that are difficult for women with FASD, such as goal directed thought, integration and synthesis of information, understanding cause and effect, organizational skills, and reading cues and signals from others or from situations. Having difficulties in some or all of these areas may seriously impact a woman's ability to keep herself safe.

Remember—goals designed to help one woman may do nothing to help another. It is vitally important to know a woman's individual strengths and difficulties.

The level of support that each woman will need will vary depending on a number of factors, including her own challenges and strengths, resources, supports and support needs. Your work will be:

- To identify key supports and resources that a woman can draw upon. Find out who is part of her support circle. If a woman has a support network this will be a huge benefit in the safety planning process. If not, it will be important to work with her to build her support community and expand her own safety net. Integrated case management and care planning can make a huge difference to safety for women with FASD.
- To involve her existing support network in the safety planning process.
- To spend time with her talking through her unique situation and exploring together the risks and protective factors in her life. It is likely that this process, as in the case of women with mental health and/or substance use concerns, will require focused time and energy because of the added complexity of the task.

During periods of transition, support needs are likely to be at their highest.

The following suggestions can be used to help guide your work around safety assessments and planning with women who struggle with cognitive and development disabilities, including FASD.

Attitude—Understand yourself in this work

- Shift your own attitude so that you drop your assumptions about a woman.
- Be patient and relaxed in your approach.
- Even more than usual individualize the support you provide.
- A woman may be more likely to agree and comply with your ideas and suggestions to please you or because she is lacking in confidence or because she does not understand what you want her to do. Be wary of this and of leading a woman to decisions that are not hers.
- Look for successes and wherever possible recognize them with her.

Find ways to give the message that the woman with FASD has strengths and is capable of making good choices.

Communication

- Avoid technical terms.
- Avoid asking questions you already know the answers to.
- Don't speak too fast.
- Help the woman stay on track by rephrasing questions and providing structure to the subject you are discussing.
- A woman may be very literal in her communication, so avoid words or phrases with double meanings.

- Don't interrupt the woman.
- Ask the woman to reflect back what she has heard to check she has understood you.
- Limit the amount of information presented to her at once.

Structure your work together

- Routine is important—keep to routines with appointments as far as possible.
- Provide gentle reminders—be creative in thinking about reminder tools and aids for her that will not create more dangers.
- Keep sessions short and focused—ask her to tell you (and watch for) times when she is struggling to concentrate.
- Go over the focus of the work of each session before and after each session to help memory retention.

Help women to identify unsafe situations

- Give her opportunities to talk through situations and help her to make sense of them by providing feedback, emphasizing the consequences or potential consequences of situations.
- Where possible (if she can generalize and anticipate) help her to recognize similar situations and the warning cues she may get and think through strategies to help her to know when to act on these warning signs.
- Help her to recognize her own warning signs that things are escalating.
- Help her to recognize her signs of stress and try to prevent sensory overload.
- Create a list of step-by-step instructions to guide her on dealing with unsafe situations (provided this does not place her in danger). Perhaps use visuals: pictures of people who are unsafe in her life, draw rooms of her home and have pictures showing her going to a safer room when she is being assaulted. Pictures of her taking a cell phone with her when she leaves home, etc. Remember that she may not be able to retain this information outside of your work together and particularly in very stressful situations of violence.

Help with decision-making

- People with FASD can be very linear in their decision-making, which makes it difficult for them to choose from a variety of options. Although this is hard to do in safety planning, limit choices and the need for decision-making—help her make a simple and doable plan that she can practice.
- Identify consequences together, as far as this is ever possible in situations where she has little control.
- Allow extra time for talking through the process.
- Provide reminders of important decisions during all sessions you have together.
- Talk about and model the steps she can take.
- Talk about and plan for transitions as these can be particularly challenging times.

■ Safety planning should be ongoing and repetitive because practicing is important for some people. The use of role plays and visual models, as well as reviewing problem-solving strategies addressing different scenarios, will help generalize safe thinking" (Hoog 2003).

Help with skill building

- Build skills in the place where the skills will be used. Where at all possible use a three step process:
 - **Modelling**—show by doing yourself.
 - **Practice with guidance**—explain how this will help and encourage her to try. Give immediate feedback while she is trying. Be prepared to do this over and over.
 - **Reinforcement of behaviour**—reinforce the new skill and the woman's ability to use it.
- Rehearse, rehearse, rehearse.
- Break new skills and concepts into very simple steps.

Helping to build and strengthen supports

- Develop a history of supports—figure out what worked and what didn't and what supports are still around today—search for any new supports that may be available.
- Involve a woman's support people in the safety planning discussions and in any plans of action and interventions.
- Accompany her to other professional appointments and if necessary explain, with her, how FASD or cognitive disability affects her and what you have both found helpful in terms of meeting her support needs.
- Explain what you know to other colleagues and help your team members see other ways of working.

Conclusion

Women with FASD are one of the most vulnerable groups of women in our society. Women with FASD are vulnerable to abuse and manipulation and to becoming involved in situations that are very hazardous to their physical, emotional, mental and spiritual wellbeing. There are also few services that support women with FASD with their extra needs as adults. There is therefore a considerable gap between the needs of women with FASD and the supports and resources available to meet these needs.

Helping a woman with assessing her risks and dangers and then helping her with safety planning is essential work that is very challenging for her and her supporters. This said, there are many possibilities for making a difference in women's lives if we are informed about the various accommodations that can be used to underpin our work together. Changing our own expectations would be a good place to start. Helping her create her own long-term support network could have a huge impact on her life, though the practical challenges of doing this within our time and resource constraints must also be fully acknowledged. The advice in the FASD world of "try differently not harder," is a reminder that we will need to think and act differently in order to effectively support a woman with FASD: get curious about how a woman understands the world, about her way of being in the world, and be creative and experimental in your responses to her. Our core values in anti-violence advocacy, support and counselling, of focusing on a woman's safety, survival, strengths and self worth, will be our main support in this work.

4.7.6 References, Resources And Further Reading

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Malbin, D. 1993. *Fetal Alcohol Syndrome/Fetal Alcohol Effects: Strategies for Professionals*. Centre City: Minnesota: Hazelden Educational Materials.

Poole, N. and C. Look, 2005. *BCRCP Guidelines for Alcohol Use in the Perinatal Period and Fetal Alcohol Spectrum Disorder*. Vancouver: BC Reproductive Care Program.

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United Way of Calgary and Area. 2004. *New Perspectives on Transitions and Fetal Alcohol Spectrum Disorders*. United Way of Calgary and Area.

VON Canada. 2005. *Let's talk FASD: Parent driven strategies for caring for children with FASD*. Ottawa: VON Canada National Office.

National Resources

Canadian Centre on Substance Abuse

www.ccsa.ca

1-800-559-4514 (toll free in Canada)

The CCSA provides information on FAS over the phone or by email. There is a searchable database at www.ccsa.ca/fas. There is also a section of recent resources on FASD found under the TOPICS section on the main page and a section on women's substance use and treatment under the TOPICS section as well.

Centre for Addiction and Mental Health (CAMH)

www.camh.net

Tel: 416-535-8501

With the backup of an extensive library of resources on the topics of Alcohol and Pregnancy and FAS, the CAMH library reference service responds to requests for information and referrals from professionals, students and the general public.

Website Resources

FASD Connections

www.fasdconnections.ca

This website has a mission to build a community where adolescents and adults with FASD are included and encouraged and their desire and potential are supported. It is an excellent resource that contains many helpful resources relevant to working with adults with FASD including sections on critical issues around FASD, a section on perspectives of those with FASD, sections on upcoming events, a forum, and sections with recent articles and resources that are easy to download. The *What's New* section includes resources on women and violence, substance use, mental health, pregnancy and sex work.

Fetal Alcohol Syndrome Consultation, Education and Training Services, Inc.

<http://www.fascets.org/index.html>

"Services available through FASCETS are designed to increase understanding, build on strengths, expand options for developing effective parenting and professional techniques, enhance existing programs and support the development of new programs. Short term goals include increased effectiveness, reduced frustration, and attainment of improved outcomes, including burnout prevention in professionals. The long term goal

of this work is to contribute to the prevention of FASD. FASCETS supports the development of a family-centered, community-based, multidisciplinary continuum of care. This collaborative design has been found to be effective in enhancing communication among parents and professionals for their mutual benefit."

Healthy Choices in Pregnancy www.hcip-bc.org

This BC based website offers extensive links to free resources on preventing alcohol use in pregnancy that violence workers may be interested in sharing with women accessing services.

4.8 Challenging Our Assumptions: Working With Women's Anger and Use of Violence

BY CATHY WELCH

In this section, we address the issue of women's anger and use of violence. As well, we look at some ways of assisting women to address angry and/or aggressive behaviour.

We will:

- review our understanding of women's relationship with anger, hostility and aggression;
- consider the connections between women's expression of anger and violence with experiences of trauma, mental health and substance use;
- explore women's use of violence; and
- examine various strategies for working with women to transform hostile and violent behaviour into more positive outcomes.

In order to effectively work with women's anger and use of violence, we must explore our own relationship with anger and violence—our own anger and violence as well as other people's. Interspersed throughout this section are some reflective questions to consider as preparation for engaging with clients in this very challenging work (see also Trauma, Mental Health and Substance Use within an Anti-Oppression Perspective).

Some questions to ask ourselves:

- What are the norms of expressing anger in my culture? How does that differ for women and men?
- What did I learn about anger and how to express anger growing up? What did I learn about women's expression of anger and violence growing up?
- What are my personal beliefs about anger and the expression of anger?

4.8.1 Thinking About Anger

Anger is an emotion that warns us that something is wrong. It can be that we are being hurt or threatened, that our rights are being violated, that our needs are not adequately being met, or that we are giving too much (Lerner 1997). We have anger to protect us. It allows us to fight back when we need to defend ourselves (or others) from threat to our well-being or to fight for something that is personally important. It motivates us to change, to take action. In and of itself, anger is an adaptive, protective and life-preserving emotion. It is simply one feeling among many.

Anger can have both positive and negative consequences. The key point here is that it is the way that we respond to and express our feelings of anger that determine the outcome. Anger that is inappropriately acted upon or expressed has enormous negative costs on our emotional, mental, physical and spiritual well being. The

constructive release of anger is healthy and can result in positive outcomes. However, the healthy, respectful expression of anger doesn't necessarily come naturally. It is a skill that has to be learned and refined.

Anger is a natural and mostly automatic response to physical or emotional pain. Pain alone is not enough to cause anger, but when pain is combined with some anger-triggering thoughts, we feel anger. Thoughts that can trigger anger include personal assessments, assumptions, evaluations or interpretations of situations that makes us think that someone else or something is attempting (consciously or not) to hurt us. As well, anger is a defensive emotion to protect us from feelings of grief, sorrow, or fear embedded in the pain.

What is my relationship to my own feelings of anger? How do I express my anger?

4.8.2 Differentiating Among Anger, Hostility And Aggression

Anger, hostility and aggression are often mistakenly considered to be one and the same. It is important to distinguish the ways in which they differ:

- Anger is an emotion. It is normal and appropriate to feel angry in response to some situations and/or people. The respectful (to ourselves and others) expression of anger is a meaningful way to inform others about the impact of their behaviour or to express one's personal limits, values, and boundaries.
- Hostility is a pervasive attitude that contributes to the violation of another person's rights, values, or boundaries. It can include brooding about perceived or real injustices as well as ways that one can get even. Hostility embodies feelings of powerlessness and can often lead to aggression or withdrawal as a means to punish.
- Aggression can be defined as a behaviour intended to physically or emotionally harm others, to pay back real or imagined wrongs. Aggression often results in disrespect for oneself and the other person and creates distance between the two people.

What is my experience of another person's anger, hostility and aggression?
How do I respond to others' expression of anger?
Have I ever felt feelings of hostility? In what context did I feel these feelings?
What were the origins of these feelings?
Have I ever felt feelings/thoughts of aggression? What was that like? Have I ever acted on these feelings/thoughts?

4.8.3 Women, Anger And Aggression

Rage corrodes our trust that anything good can occur. Something has happened to hope. And behind the loss of hope is usually anger; behind anger, pain; behind pain, usually torture of one sort or another, sometimes recent, but more often from long ago (Estes 1992).

What happens for me when I witness women's anger? What comes up when I think of women being violent? What am I afraid will happen?

Women's relationship with anger is complex. Women hold and express anger differently than men do. The outward expression of anger is not socially sanctioned in women, as it is in men. We have been socialized not to show or even be aware of our anger (Lerner 1997). We are taught to suppress our anger, to hold it in, to ignore it. When we are cut off from feeling or recognizing anger we are cut off from our capacity to fully engage or experience all of our being.

A woman who outwardly expresses her anger is feared in our society; we hold very powerful taboos against women feeling and expressing anger. Angry women are discounted, disapproved of and often pathologized. Historically, angry women have often been labelled as having borderline personality disorder. In popular culture women who use violence are generally seen as inadequate, unnaturally masculine, sick, evil or mentally disturbed.

In her book *Men, Women and Aggression*, Anne Campbell (1993) argues that aggression in men is "a means of exerting control over other people when they feel the need to reclaim power or self-esteem". She suggests that women's use of aggression is in response to "a temporary loss of control caused by overwhelming pressure and resulting in guilt".

Campbell proposes that the expression of aggression in women follows a four-step process:

- 1) control of initial anger—where the anger is felt and is contained;
- 2) through periods of crying or argument where the anger may be released and relieved if the situation improves;
- 3) physical aggression results from the continued and increasing tension (frustration) resulting in an explosion which acts as a means of release; and
- 4) the final stage is one of guilt or embarrassment at the outburst.

She suggests that the capacity for empathy is one of the main explanations for feelings of guilt following a physical outburst.

Lerner (1997) and Campbell (1993) acknowledge that there is a wide variation in how aggression is expressed and experienced within genders. They suggest that such factors as social conditioning, personality, upbringing and personal experience contribute to the greater or lesser propensity to experience anger and act aggressively. As well, cultural attitudes towards the expression of anger and aggression, and experiences of oppression—racism, classism, homophobia, etc—and violence, contribute to feelings of anger and the choices that women make in acting on those feelings.

How do the positive and negative effects of expressing my anger affect me—physically, emotionally, spiritually and mentally?

4.8.4 Mental Health, Anger And Violence

"Gender plays a significant role in mental health issues. For example, over 70 percent of people diagnosed with borderline personality disorder (BPD) are women. Those diagnosed as 'borderlines' have been stigmatized as being difficult to work with and treatment-resistant (meaning that they don't respond well to therapeutic interventions).

Continues on next page

Key symptoms of borderline that many mental health professionals found so unpalatable were responses of emotional lability [rapidly changing emotions] and profound mistrust and anger expressed in what have been considered to be manipulative and aggressive ways.

There is now much greater awareness that many of the women who have been considered borderline are in fact experiencing complex posttraumatic stress responses" (Haskell 2003).

As discussed in the section Trauma, Mental Health and Substance Use within an Anti-Oppression Perspective, popular culture and the media depict people with mental health issues as exceptionally angry and violent. Yet there is little evidence to substantiate this perception. Women who have mental health issues are not necessarily angry or violent. If a woman is angry, her anger may not be a consequence of her mental health issue, but may stem instead from other aspects of her experience. As well, she may be angry but her anger may never escalate into aggressive violent behaviour.

Given our strong cultural taboos against women's expression of anger and particularly violent behaviour, women who do express their anger are more likely to come to the attention of the justice and/or mental health system. A woman who is acting out her anger may be more likely to be medicated and diagnosed than a woman who culturally "passes" in her expression of anger. The following are several examples of women's experiences with the mental health system, criminal justice system or both as a result of their expression of anger or violence. In the first two cases, details have been changed to protect their identities and to preserve confidentiality. As you think about these women, ask yourself, what assumptions do I make about these women based on their mental health diagnoses?

Case #1

A Caucasian woman in her mid 40s is sexually assaulted by her brother-in-law. Her general demeanour is agitated, angry, easily reactive, belligerent and distrustful. The incident occurred when her brother-in-law came to her house one evening. He had been drinking. She invited him in, they talked and she offered him the couch for the night. She was awakened a couple of hours later with him on top of her, and a pillow covering her face. She struggled for some time but wasn't able to get free. The commotion eventually woke her adolescent children. Her daughter phoned the police. When the police arrive the woman is hysterical, alternating between tearful outbursts and anger. She can barely give the constable a coherent story of what happened. When he suggests she go to the hospital, she becomes very agitated and angry, yelling and swearing and refusing to go.

Several years prior to the assault, this woman was diagnosed as borderline personality disorder following an incident where her husband held her and her children (then quite small) hostage for almost twelve hours, terrorizing them with knives and a gun before he shot himself. At that time, she was so agitated and angry that she was put into a locked room on the psychiatric unit and sedated. She remained heavily medicated the entire time she was in the hospital. The belief was that it was best to keep her medicated and to not make reference to her experience. When she was released she was prescribed Ativan, Prozac and Clonazepam. Between these two incidents she received little support or counselling because she was considered borderline. She did, however, continue to be prescribed the same medications. Her mood is often agitated, easily flares into rage, and she remains distrustful of people.

Charges are laid in the sexual assault case and eventually she will have to testify in court. What kinds of supports would this woman need to be effective on the witness stand? If you were her worker, how would you

work with her? What are the challenges? Does her anger affect the way you would work with her? If she was angry as a result of the assault, and not labelled borderline, would that make a difference?

Case #2

An Aboriginal lesbian is diagnosed as bipolar because she experiences extreme mood swings and is often loud, and easily agitated. On one occasion she violently resisted being handcuffed when the police were requested to assist the mental health emergency response team in taking her to the hospital against her will, following what was believed to be an attempted suicide. Over the years, she has been given a multitude of medications, none that seem to really work. She struggles with deep depressions alternating with periods of hyperactivity, racing thoughts and angry outbursts. She has a history of physical violence and sexual abuse in childhood, in addition to extreme psychological abuse. She began drinking as a teenager when her older sister took her to a party where she was raped by her sister's boyfriend and his friend. Every year, as the anniversary of the rape approaches, she becomes agitated, restless and increasingly angry, sometimes violent—either towards herself or her property. The only time she is violent to others is when someone tries to restrain her—most often the police. These outbursts are considered to be manic episodes.

These women are given mental health diagnoses based predominantly on their behaviours (irritability, angry outbursts, and general unwillingness to co-operate with the system). The events, historical and recent, that led up to their behaviour tend to be ignored, discounted or rendered irrelevant. What is important here is that, regardless of what mental health diagnosis or diagnoses a person is given, if experiences of trauma are not taken into consideration and made a focus of healing, the potential for change may be significantly compromised.

Colin Ross (2000) suggests that experiences of trauma, especially early childhood trauma, are the most important contributing factor in all mental illnesses. This is not to say that all mental health issues are trauma based, but many are, and life experience is often the cause for psychiatric disorders (Ross and Pam 1995).

4.8.5 Women And Violent Crime

How do you think a woman's race, class, sexual orientation and/or gender expression might play a role in how she is perceived if she verbally expresses her anger? What if she is violent? How might systems respond?

Violent crime is more often committed by men than by women. According to 1991 Statistics Canada figures, 88% of all those charged with violent crime were men, 12% were women. Women are more likely to be charged with minor assaults, property crime and fraud. Eighty percent of the women in prison have been convicted of economic related offences (Elizabeth Fry Society 2007). When women do commit violent crimes, such as murder, they are often sensationalized and demonized by the media. Women who commit violent crime generally show high rates of violent childhood experiences of sexual abuse, extending over a long period of time and with multiple perpetrators. Often the violence these women experience extends well into adult life. Incarcerated women also face added factors of racism, classism, poverty, lack of education (average level of education amongst women in federal prisons is grade nine), marginalization and isolation (Elizabeth Fry Society 2007).

Case #3

Yvonne Johnson told her story in the book *Stolen Life: The Journey of a Cree Woman*, which she co-authored with Rudy Wiebe (1998). Johnson tells a story of a life full of violence, stemming from a very early age, sexual and physical violence by multiple perpetrators, racism, poverty, and growing up in an alcoholic family. Her adult life is a continuation of the violence of her youth. She is one of four people convicted of the murder of Chuck Skwarok in 1989. She believed that he was a child molester and a threat to her children. While intoxicated, Johnson participated in his torture and beating. Johnson was so fearful that her children might be abused that she would do anything to protect them. She was sentenced to life in prison, a much more severe sentence than her male co-accuseds received.

Case #4

Aileen Wuornos was convicted of the murders of six men and was sentenced to death and executed in Florida. The movie *Monster* is based on her life. Wuornos was a lesbian, white, poor, abandoned and abused as a child, raped, impregnated and forced to give up her child as a teenager. As an adult she was isolated, addicted to alcohol and drugs and engaged in survival sex to feed and house herself and her lover. She experienced a very violent rape by a trick, and after that when tricks got potentially violent, controlling, etc. she experienced flashbacks and killed them. Her trauma background was regarded as irrelevant in court. She was convicted and put to death. In the course of the court process she was diagnosed as a borderline personality and her behaviour described as psychopathic.

In general, crime rates are declining, but the numbers of women being incarcerated is growing. Worldwide, there is a trend for women to be the fastest growing prison population. This is especially true for young women of colour living in poverty. The overwhelming majority of women in Canadian federal prisons are Aboriginal women. In Ontario, Black women are seven times more likely to be incarcerated as white women for similar offences (Council of Elizabeth Fry Societies of Ontario). Girls are more likely to be sent to prison for minor crimes, due to vulnerability and inequality. Homelessness and survival sex are often factors in young women's criminalization (Elizabeth Fry Society, 2007).

4.8.6 Trauma And Its Relationship With Anger And Violence

"Expressing anger and engaging in controlling behaviours are important to acknowledge as part of the range of responses that individuals might have to violence" (Ristock 2002a).

The psychological, physiological, behavioural, and social impacts of trauma in the lives of women and girls are complex and are discussed elsewhere in this tool kit and by numerous other authors (see for example Herman 1992; Briere 1996; van der Kolk, McFarlane and Wisaeth 1996; Ross 2000; and Haskell 2003). Our purpose here is to focus solely on those aspects of the disruptions to a survivor's capacity to modulate emotions (affect regulation), specifically anger and rage. Our hope is to create a context, and hopefully, make space for the understanding of the expression of anger and aggression by women who are both survivors and perpetrators of violence. Our intention is not in any way to discount or minimize the destructive nature of violence and aggression, nor to deny responsibility for one's violent behaviour(s).

We need to acknowledge and understand the contexts and motivations for a woman's use of violence, while at the same time holding her accountable for her actions.

Anger is a natural consequence of trauma, where physical, emotional, spiritual and/or sexual integrity is attacked or compromised. Experiences of childhood sexual abuse can result in chronic irritability, unexpected or uncontrollable feelings of anger, and difficulties with the expression of anger (Briere 1996). There is a tendency to either suppress feelings of anger or to misdirect the expression of anger. Either situation can be detrimental. Angry feelings that are suppressed can become internalized as self-hatred and depression, which in turn may be a motivating factor in the expression of self-harming behaviours. The external expression of anger and rage resulting from experiences of childhood abuse may "increase the likelihood of—but in no way guarantees—aggressive behaviour" (Briere 1996). Van der Kolk (1996) suggests that in trauma survivors, extreme feelings of anger and helplessness may be expressions of reliving the trauma.

As well, emotionally intense and overwhelming feelings of anger and rage may be dissociated. As Lori Haskell (2003) explains, "the emotional arousal at the time of the traumatic event is often so overwhelming that the woman may need to disconnect from her feelings to survive. The terror and disconnection she experiences is not coded as a typical memory, but rather as a series of disconnected emotions, visual perceptions and sensation." The result when these disconnected feelings of anger are triggered is a seemingly uncontrollable expression of rage that may manifest as emotional or physical aggression.

Yvonne Johnson, writing in her journal in prison, reflected on how she had come to understand her motivations and actions:

"...because of past abuse ... relapses into mental anguish and body memories channelled into mental confusion, which in effect cause physical reactions to the nervous system, where all physical, mental, spiritual [faculties] can't have up-front knowledge to recognize what in effect is happening. Where memories and emotions arise. Yet [my] mental and physical [faculties] couldn't co-exist then to recognize what was happening. But now I do. I see for the first time in my life, to understand. I am not crazy. I must ponder this idea more. ... I was defeated before I recognized it. But now I can put a name to it, to attempt to explain it now. It is not incurable. I can cure myself, since I have a reason that caused it. So if I deal with the reason, then I can work to make the problem go away. (Wiebe and Johnson 1998)

A key feature of a trauma survivor's experience is extreme emotional states that alternate between hyperarousal and numbing or shutting down emotionally when a threat is perceived (van der Kolk and McFarlane 1996). Emotions shift from being totally "on" or totally "off" with little capacity to modulate the intensity, or to interrupt the cyclical shifting from feeling overwhelmed to emotionally shut down. In essence, the nervous system becomes overactive, alternating between rage, panic, hypervigilance and, at the other extreme, depression, deadness, disconnection and exhaustion. The cycling can be rapid, or a person may experience times when they become stuck in one state or the other for extended periods of time.

Ordinarily, our nervous system serves to alert us to pay attention to potentially important situations. When we become chronically hyperaroused we lose that capacity and become easily triggered in response to minor stimuli as if we were experiencing a major threat; setting off intense feelings of panic, fear, anxiety and anger. Thus, we lose the capacity to rely on our own bodily sensations to warn us of potential danger. As well, our ability to accurately decipher the messages our nervous system is sending us and to articulate what we are feeling is greatly compromised. What we are left with is a narrowed range of emotion, where we overreact and may threaten others or shut down and freeze, and a tendency to go immediately from stimulus (fear) to response (fight or flight) without realizing what made us upset (van der Kolk and McFarlane 1996; Haskell 2003).

4.8.7 Relationship Between Substance Use/Withdrawal And Anger¹

The relationship between anger and violence and substance use and withdrawal is not simple and often may be very individual. Substance use generally does not cause anger or violent behaviour, although the use of substances may increase aggressive reactions and lower one's inhibitions to acting on persistent feelings of anger. Alternatively, in some people, substance use may block the expression of anger and create a sort of 'numbing' effect. Amongst women in prison, the links between substance use and violence are significant and Steffensmeier (1995) suggested that women were more likely, than were men, to commit an offence while under the influence of alcohol or drugs. Even when a person stops using alcohol or drugs, the anger and the reasons behind the anger remain. Feelings of anger will not be processed unless they are dealt with directly.

The following discussion explores some specific ways that some substances affect feelings of anger and the potential for violence. Information is also included on the process of withdrawal and its effects on nervous system arousal and irritability.

Psychiatric medication (anti-depressants, anti-anxiety medications—including benzodiazepines—and anti-psychotic medications) are not typically associated with increased incidence of anger, unless the person has an adverse reaction to the drug, in which case this could cause irritability. But if withdrawal from any of these medications is abrupt, increased agitation, anger, and aggression are likely. In fact, aggravated anger and hostility has been found to be a common response to benzodiazepine withdrawal.

The most common over the counter drugs to be linked to increased anger and aggression are steroids. Yet there are reports of mild to moderate agitation as an adverse reaction to central nervous system stimulants, such as caffeine. Ephedrine, a stimulant frequently used as an appetite suppressant, is also associated with mild to moderate agitation. And even Tylenol, which is most frequently used for pain relief, is reported to be linked to increased irritability in some cases. In fact, many medications, including herbals, can produce unpleasant symptoms and behaviour changes when discontinued.

Crystal meth is the illicit drug most highly associated with increased anger and aggression during use and withdrawal. Cocaine and heroin produce strong irritability while coming down from the drug. Heroin and other opiates produce many uncomfortable symptoms during withdrawal, including agitation, but cocaine produces relatively mild withdrawal symptoms. Marijuana withdrawal symptoms can include irritability and anger.

Withdrawal from nicotine is also reported to cause anger, irritability, and aggression. Mild to severe agitation is associated with alcohol withdrawal.

Withdrawal Process, Anger And Violence

While in active addiction, there is artificial stimulation and disruption to normal brain activity, which impairs clear thinking and how emotions are expressed.

The process of withdrawal from substances starts with an acute, intense, and immediate withdrawal. Post-acute withdrawal symptoms generally appear seven to 14 days into abstinence, during the stabilization phase, and can last anywhere from six months to two years.

The severity of the post-acute withdrawal symptoms usually depends on two factors. The first is the amount and degree of brain dysfunction or disruption that has been caused by the length of use, and type of chemicals used, and any injuries that occurred associated with the use. The second is the severity of the psychological and social stressors that may occur in early recovery.

¹ Many thanks to Mireille LaClaire for her invaluable work on this section.

During the adjustment period, difficulty in thinking clearly, expressing emotions, memory, coordination, sleep disturbances and stress are all common. The physical and emotional symptoms of post-acute withdrawal occur in random cycles during recovery, and are often misdiagnosed as other disorders (manic depression is one of the most common).

It takes time for the brain to right itself as neurotransmitters return to normalcy and adapt to a life without mood altering chemicals.

4.8.8 Women's Use Of Violence

"The image of a victim as pure, innocent and helpless looms large in dominant culture, and makes it difficult to speak about agency, strength, and resiliency, and even a 'taste' for revenge as other features of being a victim" (Ristock 2003).

Women's use of violence is difficult for many feminist anti-violence workers to accept. We have discounted women's violence and clung to the myth that women aren't violent, focusing our attention on the real and devastating impact of men's violence towards girls and women. In our attempts to counter assertions of mutual abuse, we have minimized and glossed over women's desires to talk about their own use of violence.

"The simplistic notion that males are violent and females are not contains a grain of truth, but misses the complexity and texture of women's lives" (Simpson 1991). When feminists side step the issue of women's use of violence, there is no effective response to those who claim that women are just as violent as men, or to others who perpetuate the myth that women who use violence are extraordinary freaks. This lack of discussion denies women agency or choice in their lives and leaves society with little understanding of women's use of violence and how we should respond and help women heal.

4.8.9 Women's Use Of Violence In Intimate Relationships

Heterosexual Relationships

It is undeniable that some women use violence towards their male partners. In order to effectively address and intervene with women's use of violence we need to keep sight of the differing patterns, contexts, motivations, and consequences that usually occur in women's and men's use of violence (Worcester 2002).

In a recent article, Ellen Pence and Shamita Das Dasgupta (2006) advocate for the return to the use of the term "battering" as a way to move away from the trend to gender-neutralize violence in heterosexual relationships and distinguish among the five categories of violence that they identified in their research²:

- 1) battering as an ongoing pattern of intimidation, coercion, violence and other tactics used to establish and maintain power and control over an intimate partner
- 2) resistive or reactive violence
- 3) situational violence—where no pattern of abuse is present
- 4) pathological violence—violence stemming from the use of alcohol or drugs, mental health issues, physical disorders, and/or neurological damage. In these cases, when the pathology ends, so does the violence
- 5) "anti-social" violence, where violence is not restricted to a particular partner and gender and is more generalized

² Their conceptualization of violence in this manner is a result of 15 years of interviews with men and women arrested for domestic abuse and the review of hundreds of police and court documents in the United States.

Their intention in this delineation is to deepen our understanding of how violence is used by both men and women in relationships, and to develop interventions that address the specific form of violence used.

In recent years, there has been an abundance of studies that look at men's and women's use of violence in relationships. Many of these studies fail to consider the possibility that women and men experience and use violence for different reasons and under different circumstances (Das Dasgupta 2001). Pence and Das Dasgupta (2006) point out that while it is not uncommon for women to use violence in intimate relationships, "it is exceptional for her to achieve the kind of dominance over her male partner that characterizes battering." The overwhelming majority of women in their study used violence to resist their partner's violence, often in conjunction with drug and alcohol use. Other studies of women's use of violence in heterosexual relationships corroborate the low incidence of women as "primary aggressors" maintaining a regime of domination and terror over their male partners (Hamlett 1998; House n.d.; Swan and Snow 2006). Heterosexual women who have sought service through the Women Who Use Violence Project in Victoria, BC³ were motivated to use violence for at least one of the following reasons:

- a) in self-defense, as a way of protecting themselves and their children against their partner's abuse;
- b) in retaliation, to pay back an abusive partner; and
- c) to express feelings of frustration at being controlled or invalidated or as a way to be heard by their partner (Marleau, pers.com).

Lesbian, Bisexual, Transgender and Queer (LBTQ) Relationships

"Abuse is always inexcusable ... there are many different kinds of abusive relationships and many reasons for why it happens. ... we need to understand those differences so that we can respond in more helpful ways. The same responses are not appropriate for someone who has experienced abuse her whole life and occupied both the perpetrator and victim positions, someone else who has been terrorized by her first lesbian lover, someone else who uses violence to retaliate against an abusive partner, and someone else who has experienced shifting power dynamics where both she and her partner have been verbally and emotionally abusive. The violence still has to stop; in looking at these contexts, I am not saying that women are not responsible for abuse, but I do think we need different ways of responding that attend to the complexities of these differing power dynamics" (Ristock 2002a).

Since the mid-1980s, advocates working on the issue of violence in same-sex relationships have challenged the myth that women are not violent and that women do not use violence in relationships (see Hart 1986; Renzetti 1992; Kaschak 2001; Ristock 2002a). The challenges of effectively responding to the issues of same-gender relationship violence are multi-faceted and deeply seated in women's experience of oppression and violence in a patriarchal and misogynist society, and the added intersection of homophobia and transphobia in a heterosexist and transphobic society. For instance, from the perspective of the anti-violence field:

- a) acknowledging women's use of violence has been seen as detracting from the very real and devastating impact of men's violence against women;
- b) acknowledging that women are violent challenges traditional notions of power and control and victim/perpetrator dichotomy;
- c) Working with women and their use of violence poses difficulties in determining who is violent and who is not; and
- d) Working with women who have perpetuated violence creates challenges in providing service in a safe and secure manner.

³ The Women Who Use Violence Project is a community collaboration amongst various community and anti-violence agencies in Victoria, BC. The project, originally conceptualized by Alayne Hamilton and Jude Marleau, began in 1997/8.

From the perspective of the LGBTQ community, addressing issues of violence in relationships feeds into:

- a) the stigma of being marginalized
- b) a fear of further marginalization by providing evidence that a LGBTQ sexual identity or a transgender identity is unhealthy; and
- c) fear of experiencing homophobia and/or transphobia when seeking help.

While this is changing, these challenges still remain and feed ongoing discussions and debate within the anti-violence and LGBTQ communities.

In what ways is my agency a safe place for LGBTQ people to access services? In what ways is it not a safe place for LGBTQ people? How do we make our services accessible to LGBTQ people? What challenges would this pose for our agency? In what ways does/could our service think and work outside the gender binary system? What would it mean to our program to move beyond the dichotomy of victim or perpetrator and work from a "both/and" perspective?

While the issue of assessment of who is violent in same-gender relationships is complex and beyond the scope of this tool kit⁴, it is, however, important to be aware of the context, intent and effect of women's use of violence in LGBTQ relationships in order to accurately determine what service is required. In her book, *No More Secrets: Violence in Lesbian Relationships*, Janis Ristock (2002a) identified three basic styles of relationship dynamics:

- 1) A pattern where there is a distinct perpetrator and victim and that follows a predictable cyclical manner that intensifies over time;
- 2) Fluctuating power dynamics, where the violence is more relational in nature and there is no distinct perpetrator or victim and no clear pattern to the abuse; and
- 3) Fighting back in response to violence. In her study, the reasons for fighting back included fighting back as a way of coping, as a form of resistance, as an intentional act to cause harm and/or a self-defense reaction.

4.8.10 Women's Use Of Violence Towards Children

Women's use of physical violence towards children is something that has been difficult for us to acknowledge. Yet, just as women's use of violence in relationships needs to be recognized and discussed in the context of societal and interpersonal pressures, so does the use of violence towards children. Washburne (1983) suggests that women's abuse of children is a direct result of their own oppression in society and within the family. Women's motivations for abusing children can be complex, and often are related to their own experiences of abuse. Such factors as isolation, stress and lack of support, poverty, cultural beliefs and practices, and learned behaviour and parenting styles, have all been suggested as explanations for women's use of violence towards children.

Regardless of the reasons for women's use of violence towards children, our role as counsellors and support workers is to help women find ways of disciplining and relating to children in a non-violent manner, and dealing with their own anger and stress. We have a legal obligation to report child abuse, but we can engage with a woman to support her in reporting and getting help to make changes (see section Empowering Strategies When Children are at Risk).

⁴ For a fuller discussion of assessment issues see: Hamlett (1998), Ristock (2002a, 2002b), and Northwest Network of Bisexual, Trans and Lesbian Survivors of Abuse (www.nwnetwork.org).

4.8.11 Strategies For Working With Women's Anger And Violence

The discussion below focuses on the use of violence in relationships. We acknowledge that women use anger and violence in other situations as well. Many of the strategies for intervention outlined in this section are by no means unique to violence in intimate relationships and can be effective in helping women deal with the expression of anger and the use of violence in other situations. Much of the literature that outlines strategies for dealing with women's use of violence specifically, rather than strategies intended for men and extrapolated to women, has been developed for women who use violence in relationships. As well, many anti-violence workers are faced with women who want to work on their use of violence in their relationships.

What comes up for me when I think of addressing issues of women's anger and/or use of violence? What supports would I need from my agency, supervisor, and colleagues in order to work with women on these issues?

Motivations For Women's Use Of Violence

Following from the above discussion, women's use of violence in intimate relationships (including heterosexual and LBTQ relationships)⁵ can be separated roughly into four main categories:

Primary physical aggressors

Women who use tactics of power and control, including violent behaviour, to control their partners can be considered to be primary aggressors. According to Hamlett (1998), the number of women in her program that are considered primary aggressors is small and most are violent to a female partner. These women generally have histories of growing up in abusive households, witnessing the abuse of their mothers, and often experienced physical and/or sexual abuse themselves and have identified with the perpetrator. Often these women possess a sense of entitlement justifying their use of violence. Some women have histories of violent behavior in their teen years, and may have been abused in at least one adult relationship.

Relational or Situational violence

This is where violence is used to achieve goals, without any pattern of control or domination and where power fluctuates back and forth continuously in the relationship. The use of violence in this relationship is unusual and generally arises in highly stressful situations. Either partner may use violence, but they do not attempt to dominate each other in other ways.

Self-defence

The overwhelming majority of women who are violent are acting in self-defence. Often a woman is trying to get away from a violent incident or when she knows her partner is about to be abusive. This generally is the situation with women who are abusive to male partners. She may also be fighting back in retaliation to physical, emotional and psychological abuse. This is common in abusive lesbian relationships.

"Never-again" mode

Some women, regardless of the gender of their partner, move into a survival mode of thinking, "no one is ever going to hurt me that way again," and use violence as a way of protecting themselves. These women, almost without exception, have experienced violence in at least one adult relationship, and often have histories of childhood abuse.

⁵ Based on and adapted from materials in Hamlett (1998), Pence and Das Dasgupta (2006) and Ristock (2002a).

Notes to Table 1

(Please refer to Table 1 on next page)

Understanding what motivates a woman to use violence is essential in developing an intervention that fits for her and has the opportunity for a positive outcome. Table 1 suggests possible interventions that may be most effective with women whose violence arises out of the differing motivations, as outlined above. It is important to recognize that there may be some overlap between these categories, and the interventions need to be congruent with an individual woman's specific circumstances. Presented here is a broad framework for addressing each grouping, as well as suggestions of specific skills and information that might prove helpful. These are not exhaustive. There are many issues that can be addressed, but we have tried to put forward those points that are most pertinent. The categories are not necessarily mutually exclusive; for example, a woman who is abused in one relationship and takes a stance of "never-again" in a subsequent relationship runs the risk of becoming the primary aggressor in that relationship, although that is not a given.

Table 1. Main Categories of Women's Use of Violence in Relationships and Possible Interventions⁶.

WOMEN'S USE OF VIOLENCE	DEFINITION	POSSIBLE INTERVENTIONS	SPECIFIC SKILLS AND KNOWLEDGE TO ENHANCE	OTHER CONSIDERATIONS
PRIMARY AGGRESSOR	An ongoing pattern of intimidation, coercion and violence to establish and maintain dominance over an intimate partner. A primary aggressor often feels a sense of entitlement that justifies her violence.	<ul style="list-style-type: none"> • change beliefs • needs to take responsibility for her behaviour • learn to stop violent behaviour • focus on keeping partner safe • learn to establish a more equitable power base • provide external monitoring 	<ul style="list-style-type: none"> • safety and containment • affect management skills • plan for avoiding violence • recognize and manage triggers and cues • understanding abuse and its impact on others/self • identify irrational beliefs, negative self talk, self-control • respectful expression of anger • communication skills 	Programming needs to be similar to the type of programming for abusive men, but designed specifically for women and incorporate a framework of intersectionality (Ristock 2005). ¹
RELATIONAL VIOLENCE	Relational between partners and is used to achieve goals without any pattern of power and control, intimidation, and domination.	<ul style="list-style-type: none"> • create behavioural options • resolve issues resulting in conflict • provide counselling 	<ul style="list-style-type: none"> • all strategies listed above • for primary aggressor • strategies for resolving conflict • counselling to resolve any past trauma 	A thorough assessment of the dynamics in the relationship is important to distinguish this from the primary aggressor.
SELF-DEFENCE	Violence used in defending one-self from another's violence. The violence may be used in retaliation, as a coping strategy, as a form of resistance.	<ul style="list-style-type: none"> • develop ways to get and stay safe • provide information about violence in relationships 	<ul style="list-style-type: none"> • safety planning • safety and containment • affect management skills • understanding abuse and its impact • respectful expression of anger 	Often this form of violence ends when the abuse stops.
"NEVER-AGAIN" MODE	This is a form of survival thinking where abuse is used to protect oneself from being abused. This may occur within a relationship where abuse has been present but has stopped or when entering a new relationship.	<ul style="list-style-type: none"> • develop ways to stop her violence • learn to assess her own safety level • ensure partner's safety from abuse • provide counselling 	<ul style="list-style-type: none"> • safety planning • all strategies listed above for primary aggressor • strategies for resolving conflict • counselling to resolve past abuse 	This woman may have difficulty interpreting her partner's behaviour or in distinguishing "early warning signs of abuse."

⁶ This table is compiled from information from multiple sources, including Hamlett (1998), Pence and Das Dasgupta (2006), and Ristock (2002a), Jude Marleau (pers com), and the author's own experience in working in the Women Who Use Violence Program.

The following are some questions that may be helpful in assessing a woman's use of violence and in making decisions on what interventions would be most useful. These can be used in conjunction with other assessment tools or questions in determining an overall plan of action or as general questions to guide you in engaging with a woman around her use of violence.⁷

It is important to keep in mind that the behaviour itself is not the point. Virtually any behaviour can be used by a person to survive violence or to establish power and control over another. What is crucial in assessing dynamics of abuse in relationships is a) the context in which the behaviour occurs; b) the intent of its use; and c) the effect of the behaviour.

Relationship Violence

- How long have you been in this relationship?
- Have you ever been separated?
- Are you together now?
- When did the violence or abuse begin in your relationship?
- How often has it happened? (Length of cycle?)
- Is there a pattern of issues or circumstances that lead up to the violence or abuse?
- When do you use violence? In what circumstances?
- When was the most recent incident of violence or abuse? Describe what happened.
- What led up to this violent incident?
- What motivated you to use violence in this instance?
- How do you understand your use of violence?
- What were you hoping would be the outcome of your use of violence?
- What effect did your use of violence have on your partner?
- What impact did your use of violence have on you?
- Has the violence or abuse increased in intensity or frequency?
- Describe your most violent incident against your current partner.
- What injuries has your partner had? Has your partner ever required medical treatment?
- Has your partner ever needed medical treatment but not received it?
- What injuries have you had?
- Do you and your partner have disagreements about sex? What kind of disagreements?
- Do the disagreements get resolved? If so, how?
- Do you pressure your partner to be sexual when she/he does not want to be?
- Does your partner pressure you?
- In general, how do you handle disagreements in your relationship?
- In general, what do you think your reasons are for using violence?

Violence In Other Relationships

- As an adult have you been physically violent to:
 - Parents or in-laws
 - Siblings
 - Friends
 - Children
 - Strangers
- Were you ever abused in past relationships?
- Were you ever abusive towards another partner?
- Describe your most violent incident toward your past partner.

⁷ These questions form part of the assessment used in the Women Who Use Violence Project, developed initially by Jude Marleau and revised by Cathy Welch.

Impact On Children

- Have you or your partner ever received help or intervention because of abuse toward the children?
- Has the Ministry of Children and Family Development ever been involved? If yes, how so?

Childhood

- Did either of your parents/caregivers have a problem with alcohol or drugs or a mental health issue?
- Did either of your parents/caregivers use violence or abuse towards the other?
- What was it like growing up in your family?

Criminal Justice System Involvement

- Have the police ever been called to your house because of an incident of violence between you and your partner?
- Have you ever been charged with spousal assault?
- What was the outcome?
- What is the status of any current charges?
- Are there any current protective orders in place?
- Has your partner ever been charged with spousal assault?
- What was the outcome?
- Are there any current charges?

Strategies For Addressing Angry Or Violent Behaviour

The following discussion looks at some specific exercises and information that can be used with women to help them to become aware of their behaviour, what fuels that behaviour and to develop skills and strategies for change. These are examples of the kinds of tools that anti-violence workers, whether Community-Based Victim Service Workers, Outreach Workers or STV Counsellors, can use to assist clients. . In some sub-sections are hand-outs that can be photocopied and given out as "homework" or discussed in session. These handouts were originally developed for a woman who use violence group⁸ and thus can be used in both an individual and group format. The materials were originally designed for women who are violent to a female partner because LGBTQ people in our society so often have to "translate" material to make it relevant. Gender neutral language is typically used and in some cases a variety of situations are presented; thus these materials can be used with any woman regardless of sexual orientation or affectional preference. Working to end violence in any relationship is part of the bigger goal of working to end violence and oppression in the broader culture.

How have I learned to address and work through my feelings of anger? How have I learned to transform them into positive action? What skills have I learned that might be helpful to another woman?

Creating Alternatives To Anger And Violence

Women who are seeking to find alternatives to their inappropriate expression of anger and/or use of violence and who are working towards a vision of life without violence need to:

- develop an understanding of what abuse is
- understand the factors that contribute to abuse and violence
- gain insight into their behaviour
- develop a variety of tools that they can use to begin to shift their behaviour.

⁸ Adapted from materials developed by Hamlett, N. 1998. Women Who Abuse in Intimate Relationships. Domestic Abuse Project, Minneapolis, MN.

We know that the main factors that contribute to the decision to use violence, no matter what the motivation, include:

- Violence as a learned behaviour. Violence and abuse are learned from such sources as family of origin, past experiences of violence, and socialization. While women are not socialized to be in control or be aggressive in the same way that men are in our culture, women may learn that violence is a normal response of powerful people or that violence is a way of gaining power. We may also learn that violence is a way to solve problems, resolve conflicts, and express or cover up strong feelings. As well, using violence without experiencing any negative consequences can be a powerful reinforcement for future violence. Our role in assisting a woman to make changes in her life can be to help her understand where and how she learned that violence was an appropriate way of behaving, while at the same time holding her responsible for her violent behaviour.
- Opportunity to be abusive or use violence. There are numerous cultural messages that support violence as an acceptable way of meeting one's needs. As well, experiences of oppression and violations by institutions and systems, and isolation, all contribute to providing fertile ground in which violence can occur. It may be useful to engage in a discussion of the societal, institutional and personal opportunities that contribute to her use of violence.
- Stress. The ways in which stress can contribute to the use of violence and abuse include: a restricted ability to recognize one's feelings, difficulty in the ability to express one's feelings and/or needs, an association of anger and violence as being linked (i.e. can't be angry without being violent), the association of violence with power (the only way to be powerful—or not submissive—is to be violent), and the use of violence to reduce stress. Helping women to understand emotions and stress and developing a variety of ways to manage stress levels can be useful.
- Choice. In every situation there is a point at which the individual makes the decision to use violence/abuse. Sometimes the person imagines the situation before it occurs and mentally rehearses what she will do. At other times the person is unaware of the point at which she makes the choice. Regardless of why a person chooses violence, it is still a behaviour of choice that has its costs and its benefits or payoffs. In her decision to move towards non-violence it is helpful for her to consider what the negative consequences of her behaviour are as well as what she gets out of being abusive. The payoffs for abusive behaviour are usually short-term and temporary. In contrast, the costs are often long-term and permanent (loss of relationship, loss of intimacy in the relationship, limited or no visitation with children, etc.).

Violent and abusive behaviour is learned and is a choice for which alternatives can also be learned. Women need to learn to choose non-violent behaviour to solve problems, get needs met, deal with strong emotions, etc. The strategies that follow can be used as one aspect of a woman's journey to living without violence. In addition, information on such issues as emotions other than anger, violence in relationships and the progression of violence, effects of violence on children, boundaries, assertiveness, non-violent communication skills, etc. are an intricate part of her healing. We have not included handouts and discussions of these topics, as there is a wealth of information and materials from a broad range of sources that are readily available. The strategies presented here are examples of one way of thinking about and leaning about how to move towards non-violence that have been developed specifically to address women's anger and use of violence in relationships. They are only one component of her overall journey.

Handout: **Costs And Payoffs** **For Abusive Behaviour**

It's up to you to decide whether the payoffs are worth the costs for abusive behaviour. Payoffs are usually immediate, but they do not last very long. The costs, however, tend to last longer. They usually set in immediately after the abuse, but sometimes are delayed.

Payoffs are based on valid needs. For example, everyone wants to have a sense of their own personal power; everyone wants a sense of control over their life. Abusive behaviour is an unacceptable way to get one's needs met or to get payoffs. Having power and control over yourself is a much deeper and longer lasting sense of power.

Full acceptance of responsibility for your abusive actions includes accepting the costs and payoffs. As unpleasant as the costs are, when you accept the consequences of your violence, you are beginning to take responsibility for it.

Payoffs

- Physical "rush"
- Satisfaction
- Feel better: calm and relaxed; relief from stress, tension, anger, and rage
- Using my power to control my partner
- Getting what I deserve
- Escape from: shame, fear, hurt, sadness, institutionalized homophobia or heterosexism
- Get my way
- Get in the last word
- Make my partner do what I want and listen to me
- Give myself permission to be violent again
- I get a "quick fix"

Costs

- Shame, low self-esteem, embarrassment
- Lack of satisfaction; loss of self-respect
- More stress, tension, anger, and rage
- Ruined relationship; loss of intimacy and trust
- Legal: arrest, criminal record, jail, fees, time and energy, probation
- Keeping secrets from our friends
- Hurt my partner: loss of partner's special qualities; partner becomes angry, resentful, withdraws affection or gives only out of fear; partner leaves relationship
- Hurt my children: fear, disgust, school and behaviour problems, suicide, kids learn to use violence, lack of safety and security, loss of self-esteem
- Repeated loss of relationships over the years
- I spend years repairing the damage

Identifying Cues

The first step in developing strategies for changing angry or violent behaviour is to begin to identify the cues that precede abusive behaviour. Often anger and violence is explosive, seemingly coming out of the blue, and women feel that it was totally out of their control. Some may say that they could feel it coming but couldn't stop it. Others are much more aware of their feelings but still feel powerless to stop it. And still others use their anger and aggression quite deliberately. Below are two sheets that can be given to women to begin their work of identifying the signs of increasing stress:

- 1) Cues: What are they?
- 2) Cues worksheet

In preparing a woman to do this exercise, reassure her that this is hard work and encourage her to take care of herself in doing it. It may be helpful to walk her through the explanation of what cues are. Once she has completed her worksheet, it is important to engage her in a debriefing conversation about the experience of doing the exercise and what she learned about herself. Encourage her to see the process of escalation that leads to her choice of abuse/violence. Abuse doesn't "just happen." Help her to identify very specific cues of escalation; the more specific the cues, the more useful the information is for changing her pattern.

Responses to this exercise vary. Some women seem to intuitively understand the process, are ready to do the work, and have a good sense of self-awareness. For other women it is harder. For instance: some women may be more random thinkers and struggle with the process of getting very concrete and specific. It is often helpful to have this client describe one or more incidents, and while she does to make notes on the worksheet, and then walk her through the process of how you got from her story to identifying the cues. This may be enough to get her started. Encourage her to continue the process on her own. Still other women may have difficulty with this process because it produces feelings of anxiety or shame. In any case it is helpful to talk about how difficult this work is. In engaging in this work we are asking women to look at the very behaviours they may want to forget and push out of sight.

Anger is an emotion that warns us that something is wrong. It can be that we are being hurt or threatened, that our rights are being violated, that our needs are not adequately being met, or that we are giving too much

(Lerner 1997).

Handout: Cues—What Are They?

One of the first steps in shifting your expression of anger and violence is to identify the cues, or warning signs that you are in danger of acting abusively. They are warnings or signals given *before* an incident of violence or abuse. Your cues are part of the build-up or escalation phase in the progression of violence.

Your body and mind sends you signals to let you know that your stress levels are building. It is your responsibility to watch for your cues and to take yourself away from the situation before you become violent or abusive. Cues tell you that you are under stress. It is especially important to watch for cues that you have identified as having happened before several of your past abusive incidents.

Cues can be divided into seven different types. Within each type the level of stress can be rated as: low (1-3) on a scale of 9, where 9 is the highest), medium (4-6) and high (7-9).

- 1) Physical changes. This is the way your body registers stress and includes a variety of physical sensations that you feel as your stress builds. Some examples include: sweating, tension in jaw and neck, stomach in knots.
- 2) Emotions. These are the feelings that you feel during escalation and can include: frustration, anger, powerlessness, hurt, confusion, embarrassment, hatred, impatience, rage.
- 3) Self-talk. These are messages, often negative, that go through your brain (not out loud). These can include thoughts and plans to be abusive. Self-talk can be about yourself, your partner or the situation. Examples include: I hate this crap, I'll show you not to mess with me, I can't ever do anything right.
- 4) Red-flag words. Words that you say out loud or hear before you act out. There are two kinds of red-flag words: your partner's and your own.
 - a) My partner's red-flag words. These are words you hear your partner say before you become violent. For instance, if you escalate when your partner asks you to do the dishes, then the request is a red flag. The point is not to blame your partner, but to identify what is said that gets you to escalate your behaviour.
 - b) My red-flag words. What you hear yourself say that indicates you are escalating your behaviour. These words often come out before abuse and can include such statements as: "Don't bug me," "Leave me alone." This does not include abusive words like: "bitch," "fuck you," etc. These are part of the abuse.
- 5) Behaviors or actions. Things you do when stressed and/or escalating. Examples include: Ignoring partner, isolating, interrupting.
- 6) Mental images. Things you imagine or rehearse in your mind during your build-up. Some people say that before the explosion they picture in their minds being violent or abusive. Some other examples include: imagining your partner watching TV all day while you were working, imagining your partner saying negative things about you to friends or family.
- 7) Situations. Events, incidents and circumstances when you get angry or increase your controlling behaviours. Situational cues are somewhat different than other types of cues. Situations can happen at any time, and aren't necessarily tied to a particular level of escalation. For example, if you are cut off in traffic and your level of escalation is already high, then you will respond differently than if you were at a low level. They can include occurrences or scenarios that precede abusive behaviour or that contribute to your feeling of escalation and/or increased controlling behaviours. Some common situations include:
 - a) arguments, b) bad days at work, c) disagreements, d) holidays, e) major decisions, f) money stress

Handout: Cues Worksheet

TYPES OF CUES	LOW LEVEL 1-3	MEDIUM LEVEL 4-6	HIGH LEVEL 7-9
PHYSICAL CHANGES			
EMOTIONS			
SELF-TALK			
RED-FLAG WORDS (My partner's)			
RED-FLAG WORDS (My own)			
BEHAVIOURS/ ACTIONS			
MENTAL IMAGES (I IMAGINE ...)			
SITUATIONS			

Developing A Plan For Avoiding Violence

There are three components that go into creating a plan of action towards avoiding violence. They include:

- 1) a plan for preventing and managing stress
- 2) a plan for how to manage crisis situations
- 3) a self-control action plan

We can work with a woman to help her identify what each of these components can consist of for her.

The first part of the plan explores stress management techniques and strategies. There are many things that go into reducing and preventing stress. Stress management, generally, involves regular physical exercise to help relieve pent-up stress, activities that help relax and nurture, relaxation techniques, and other things that promote wellbeing. A minimum of 20 minutes of exercise three times a week is recommended. Some examples of things that promote relaxation and that are nurturing are: taking a bath by candle light, reading, playing musical instruments or listening to music. Relaxation techniques include activities that directly relax the body and mind, and can include breathing exercises, meditation, yoga, mindfulness exercises and massage. Other things that can work to reduce stress may include spiritual practice, nutrition, identifying and altering commitments when over-extended, and paying attention to time-management.

The second part of the plan for avoiding violence is the crisis plan. This consists of identifying strategies for learning non-abusive ways to handle a crisis. In this exercise we are beginning to help the woman develop skills of containment of abusive behaviour, and developing strategies for not only keeping her partner safe but also herself. The crisis plan should include an articulation of how and when she will take herself away from escalating emotions, a plan for communicating that to her partner, how she will use her time-out time in constructive ways, and a plan for returning to her partner or the situation. As well, the crisis plan will identify supports she can use if she needs to, and reminders of positive things (not related to the situation) she can do for herself to calm herself down; for example, grounding techniques or containment.

The third aspect is the development of a self-control plan. This involves integrating the information about cues, stress management and crisis planning into a comprehensive articulation of the levels of escalation and a corresponding plan for de-escalation. It shows how at the lower levels there are many options for interrupting the escalation process, whereas at higher levels the options become more limited. The self-control plan thus becomes not only a tool for responding to crisis, but also a means to avoid crisis.

It may be helpful to work with the woman on refining and including things in her plan that are realistic, do-able, and focused on herself, not on her partner. This may take some time to work through and is a living document that she can add to as she develops more skills and confidence.

Developing An Understanding Of The Relationship Between Core Beliefs, Behaviour And Affect

Situations, circumstances, self-talk and negative beliefs may be different for women who are controlling their partners through violence and abuse and women who are responding to a partner's control, abuse or threats by being violent themselves.

Women who are using violence and abuse as a means to control their partner, and who feel entitled to be in charge, will need to look at changing some of these basic beliefs about relationships. They will need to challenge the belief that they are entitled to get what they want, and that threats and violence are justified. They need to address core differences between a relationship based on shared power and equality and one based on power and control.

Women who are responding to partners who use abusive means to control them need to learn that *they* are only in charge of *their* behaviour, that violence is not an acceptable way to respond to violence and abuse. They need to look at how their negative core beliefs keep them feeling powerless. They must begin to be proactive in taking charge of their life in ways that are respectful to both their partner and themselves.

Often, the difference between "self-talk" and "beliefs" is difficult for women to distinguish. It is not so important that they can make clear distinctions, but that they articulate the beliefs which are often unconscious assumptions they hold about life. For instance, an example of *self-talk* could be "She is late," or "She should have called to tell me," or "He is probably out having fun, forgetting all about me." Examples of *beliefs* would be: "If she really loved me she would know I'm sitting here feeling bad," "If she loves me she will make sure I don't feel bad," "If he has fun without me, he will probably leave me," "I'm not worth loving."

Changing shame-based or other negative core beliefs relating to abuse is fundamental to becoming non-abusive. Even if one is acting in self-defense or in situations where one's partner is not being respectful, and may in fact be controlling or abusive, it is possible to impact the outcome for oneself through changing negative core beliefs and self-defeating internal messages.

Communication Skills

Learning how to communicate in ways that are respectful and nonviolent is for many women a skill to be developed. Their experience often has been seeped in violence, abuse and disrespectful ways of addressing another person. Skills that teach clear, healthy communication are another important piece of moving beyond anger, aggression and violence. There are many styles of communication and these may also vary among cultures. What may be viewed as respectful in one culture may be rude or inappropriate in another.

Specific models of communication are not included in this section as they are numerous, and many of us already work with clients in developing these skills. Information about healthy communication is readily available in books and manuals and through the Internet. Some of the key components of healthy communication include assertiveness training, use of "I" statements, strategies for effective listening, strategies for working through conflict and many other techniques and strategies.

It is important when teaching assertiveness skills to remind women that these are not simply new ways to harass one's partner, but a way to communicate what one wants. It is all too easy for those who believe they are entitled to get what they want to use this tool as another means to insist their partner do what they feel they want. It may be that negotiation and compromise will be necessary to resolve any differences. On the other hand, women who are using violence against a controlling partner need to know that being assertive rather than aggressive will not stop their partner's controlling behavior.

Whatever her situation, learning these skills can help a woman to be clear and respectful in her communication. It does not guarantee she will get what she wants, or change her partner's pattern of behavior. There may be a change in her partner. A person who has been controlled or abused may eventually, over time, learn to trust consistent assertive behaviour by an abusive woman who has stopped being violent or abusive. Such behavior may have little impact on an abusive male partner. Quite the opposite may occur. He may somehow use this new behavior to criticize and demean her further. The change for her comes in a sense of her own inner strength and power.

Discuss where silence fits into communication. Silence may be a very important piece of information about the communication patterns between people. In an abusive relationship, silence on the part of one's partner may indicate fear. Because of episodes of abuse, the partner who has been victimized may assume that if she talks to her partner, she will be abused. On the other hand, many people who are abusive control their partners

by being silent. Silence can be a control mechanism that keeps the partner anxious and uncertain about a situation. Silence can also feel punishing, abusive, and withholding.

Another consideration in discussing communication is to pay attention to non-verbal communication. A great deal of information can be transmitted via non-verbal cues. Four non-verbal cues that can be of importance in abusive relationships include:

Context: In abusive relationships, the context has a significant impact on the "shared meaning" between partners. For example, in a relationship in which no abuse took place, the question, "What did you do today?" might seem innocent. However, the same question asked by a person who has been abusive might signify a totally different understanding. Perhaps on previous occasions the question was followed by interrogation and accusations. Physical or sexual abuse may have followed. Therefore, because of the context established by abuse, the "innocent" question might provoke fear and tension in the partner being abused.

Proximity: Physical distance in abusive relationships may be used as a tool to intimidate or threaten. If a person who is abusive approaches her partner and gets within inches of his or her body and/or face, this may be a way for the abuser to exert control and to intimidate the victim.

Body language: Gestures, facial expressions, or body posture may convey threatening or intimidating messages. Clenching fists, raising a hand, scowling, or narrowing the eyes may be ways in which an abusive person uses body language to send messages of intimidation, threat and control.

Use of voice: The tone, volume and inflections of voice can have a great deal to do with the content and intent of the verbal message. Sarcasm, rage, and belittling can be conveyed with these elements.

In rebuilding trust and intimacy in a relationship after stopping the abusive behavior, the person who is abusive needs to be congruent—that is, she needs to match her words and subsequent actions. For example, saying "I love you," and then hitting the partner is incongruent. Abuse sends an incongruent message because people who abuse use behaviors that are usually reserved for people they hate with people they supposedly love and care about. Incongruent or incomplete communication puts the burden of understanding on the receiver.

In order to change the context established by abusive behavior, the person being abusive needs to be congruent and consistent. As the saying goes, "actions speak louder than words." If a person who has been abusive says to her partner, "I want to listen to what you have to say and I would like you to be honest," she has to be congruent and hear what the partner has to say without being abusive.

An assertive belief system values people's basic human rights. An assertive belief system holds that all people deserve respect. Further, discussion about assertive belief systems may clarify ways in which clients can take care of and respect themselves. Consider the question: "What is intimacy?" Open communication and active listening contribute to intimacy. Intimacy is about expression of emotion and feeling, allowing one to be vulnerable, and treating one another respectfully. Sex and physical touch are not essential parts of intimacy. Obstacles to intimacy include: fear of abandonment, fear of exposure and loss of control.

Often women who are trying to stop being abusive feel that their only option is to withdraw or become passive, to say nothing rather than to become violent. Teaching communication skills is a way to help them take a step further, to state clearly their need or desire. Being able to do this often helps women to not escalate when in the past they would escalate. This takes a great deal of practice over months. It is important that women get ongoing support as they change these behaviors, and that they not expect praise from their partners who are dealing with their own process.

Conclusion

Women's use of anger and violence is often intricately related to their lived experience of childhood abuse and violence, adult victimization, and marginalization and oppression in a patriarchal society where sexism, classism, racism, homophobia and heterosexism, transphobia, and experiences of colonization abound. Our role as anti-violence workers is to engage with a woman in not only the ways that she is victimized by other's violence but also in the ways she uses her anger and aggression towards others. Her healing is dependent on examining all of who she is, including those aspects of self that are "not so pretty." Whether she uses her anger and violence to defend herself from abuse, to keep herself safe from being abused "yet again," or to control a situation or a person, we can help her find ways to learn new skills and to develop strategies that are based in respect and nonviolence.

The specific strategies to address and help women find alternatives to angry and violent behaviour include a wide range of supportive and therapeutic techniques; some that speak directly to the behaviour and others that work to resolve past trauma. In this section we have outlined some specific strategies that may help women to become more aware of their behaviour, its impact on self and others, and some tools for developing new skills that we believe will be useful to both Community-Based Victim Service and Stopping the Violence workers alike.

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4.9 Empowering Strategies When Children Are at Risk

BY KASHMIR BESLA

4.9.1 Addressing Child Protection Issues With Women

An anti-violence worker and client relationship is based on trust and confidentiality, and it is most effective when these two conditions are honoured. However, there are times when a worker is unable to keep information in confidence because she has a duty to report. This section focuses on working with mothers in a situation where child protection concerns arise and must be reported to the Ministry for Children and Family Development (MCFD).

Workers are bound by law and ethics to keep information between themselves and their client confidential. The important exceptions to this are:

- If a worker's notes are ordered by the court
- If a child is in danger and in need of protection
- If a client has indicated that she will harm herself
- If a client has expressed a plan to harm others

At the onset of contact with a woman, a worker should inform her of the limits to confidentiality and the situations that arise which necessitate reporting. Although a worker has a duty to report, she can often do this without damaging her relationship with the client. The worker can remind the woman about her strengths as a parent, she can empower her with knowledge about MCFD, and she can be an advocate for the woman. With the client's consent, she can tell the social worker about the circumstances in which the woman is living:

- Is there a concern for the client's safety because of an abusive partner?
- Are there issues of mental health or substance use?
- Would the family be at greater risk of violence because of MCFD involvement?

If the woman is living in an abusive relationship, it may be beneficial to remind the social worker about *Best Practice Approaches: Child Protection and Violence Against Women* (MCFD 2004), which guides investigation and interventions for children's safety when a mother's safety is compromised by violence. The document is available on the BCASVACP's website www.endingviolence.org.

The worker can assist the client through the reporting process and still maintain a trusting relationship. In order to do this, the worker needs to keep the client informed as to what will happen once MCFD is involved in her life. Each step of the process should be explained to the client before MCFD gets involved. Many social workers are aware of the client's needs and are able to keep them informed about their file. The client has the right to know what decisions are being made for their family. The relationship will be enhanced if the client feels that the anti-violence worker and social worker are working collaboratively with her and not against her. The client should feel that she has a voice in the decisions that are being made, and this will allow her to better follow through on programs or supports that may be available to her. The client may feel that she is being judged by MCFD and that her ability to parent is in question. Creating a safe place for her fears to

be expressed will mean a great deal for her. The worker can help the client to deal with any circumstances that may arise as a result of MCFD involvement. A child apprehension is a traumatic and emotionally difficult time for parents. Having the anti-violence worker as a support and confidante can be very empowering for the client.

Workers can keep notes regarding their work with the mother. The notes should be brief and written in an objective manner, so that the content, if subpoenaed, is not misinterpreted. The notes should be written with a respectful and client-centred approach. For more information on note keeping and documentation when child protection issues exist, please see *Records Management Guidelines: Protecting Privacy for Survivors of Violence*, published by the BCASVACP and BC/Yukon Society of Transition Houses (2006; available at www.endingviolence.org).

Case #1

During a counselling session in your office, a woman says, "I was so angry with my seven-year-old son Johnny for speaking to me in such a rude tone; I slapped him across the face. Something happened to me then and I began to hit him over and over and it wasn't until he fell down the stairs that I realized what I was doing and stopped. I felt remorseful immediately. I tried to console him but he was very upset. I noticed marks on his face and I began to panic. I knew what I had done was wrong, and I could not take it back. He went to school this morning, and I'm afraid that he will tell someone. I didn't tell him not to tell, even though I wanted to. I feel like a terrible parent; it's just been so difficult being on my own."

Once a disclosure of abuse has been made, the counsellor should ask the client if she remembers a conversation about the limits to confidentiality, which they had discussed in their first session. This reminds the client that although most of what she has shared with the counsellor is confidential, there are times when the counsellor must report the information she has received.

The counsellor can offer to be with the client when she calls the Ministry to tell them what has happened. The call can be made from the counsellor's office or the client can call from her home. The counsellor should check with the client to ensure that the call has been made. She can say, "I will call you at four this afternoon, and if you have not made the call, then you know that I will have to do it for you." This allows the client to make a decision as to how the incident will be reported and by whom. If this is done in a respectful and caring manner, the relationship between the counsellor and client may not be harmed. This will also allow the counsellor to work with the client as she deals with the Ministry, and to continue to provide support around any circumstances that arise from this situation.

The worker can also ask the woman about any concerns she may have about dealing with MCFD. What fears or challenges is she thinking about? The woman may have grown up as a child in ministry care, or she may have wished that someone had intervened in her parents' life when she was growing up. It is important to be curious and pose questions that will assist the woman to understand why she is feeling a particular way, and to help her to work through her feelings.

Without minimizing the abuse towards the child, the worker should be mindful of the circumstances that can lead to such events. The client may have a history of harming her children, she may have other young children in the home that may be at risk, or she may have lost guardianship of other children to the Ministry because of her inability to parent. Or she may have a multitude of issues that are compromising her ability to parent. She may never hit the child again and would like to learn about why she got so angry and what she should have done instead. She may want to attend a parenting program to be a better parent and improve her skills or access other support services.

We can work with the woman to gain greater understanding of what is happening in her life and what she needs to be the mother she wishes to be, but the incident of abuse must be reported.

Case #2

An anti-violence worker is supporting a woman who has recently left an abusive relationship. She is dealing with the trauma of years of physical and emotional abuse by her husband. The woman has three children aged eight, six and two. She discloses that she has been consuming alcohol on a daily basis to try to cope with the stress of raising the children and trying to keep her job. The use of alcohol has increased and the woman is experiencing black outs. In a recent incident, her eight-year-old son told her that she forgot to turn the stove off after preparing some noodles for dinner. The empty pot was left on the burner causing it to smoke. Luckily the son saw it and was able to remove it from the stove and place it in the sink. He opened the windows and turned on the hood fan to clear the smoke. The mother had fallen asleep, tired from working, picking up the children from daycare, preparing dinner and drinking more each night. She reluctantly shares this incident with the worker, adding that she must have just fallen asleep because she was tired. The worker is concerned that the client is using alcohol to cope with her stress and is placing her young children at risk.

The information that the woman has provided is enough to decide that the children may be at risk. This incident must also be reported. Again, the intention is not to punish the woman, but to allow the Ministry to investigate all of the factors and make a determination. They may be able to assist her with services that will help her to cope, as well as address her misuse of alcohol. Had the eight-year-old child not noticed the scorching pot on the burner, the outcome of this incident could have been tragic. The woman may be sharing this information with the worker because she recognizes that she is not being the responsible parent that she would like to be. The report may lead to a positive outcome.

In some situations, the risk may not be as easy to determine, but the worker should not second-guess herself about reporting. She should allow the social worker to conduct their investigation and make the appropriate recommendations. If a worker is struggling about determining whether the information she has received warrants reporting, she could consult with a supervisor in her agency or with an intake worker at MCFD without disclosing identifying information.

4.9.2 Relevant Definitions Within Child Protection

The protection of children is considered one of society's greatest obligations¹

In addition to the normal rules of criminal and civil law that apply to everyone, there's also specific provincial legislation called the Child, Family and Community Service Act, which is intended to protect children from sexual and physical abuse and neglect. The Act defines a child as any person under 19.

How Are Abuse And The Neglect Of Children Defined?

The law defines these things as follows:

- "Sexual abuse" means any sexual touching or intercourse between a child and an older person, or using a child for sexual purposes.
- "Physical abuse" means any physical force or action by a parent or adult which could injure a child and which exceeds "reasonable discipline."
- "Neglect" means failing to look after the physical, emotional or medical needs of a child, so that the child's health, development or safety is endangered.

¹ This information is copied entirely from the Government of British Columbia website <http://www.gov.bc.ca/mcf/>.

You Must Report Suspected Child Abuse Or Neglect

If you have reason to believe that a child has been or is likely to be abused or neglected or is in need of protection, section 14 of the Child, Family and Community Service Act requires you to report your suspicions to the Ministry of Children and Family Development. It doesn't matter if the suspected abuser is your neighbour, patient, family member, church member or other person. Your duty to report your suspicions takes legal priority over any claim of confidentiality or privilege. It's an offence not to report suspicions of abuse or neglect. The only exception is for a lawyer who may suspect his or her client.

What Will Happen Once A Report Has Been Made?

Once a report has been made to MCFD, a social worker will go to the home or school to meet with the child and the family. The child protection social worker will:

- determine if the child needs protection;
- contact the police if a criminal investigation is required;
- coordinate a response with other agencies, if necessary.

If a child is in immediate danger, police should be called to intervene and a child protection social worker should be contacted to determine whether the child is in need of protection.

4.9.3 Fears Surrounding MCFD Involvement

As you have read, child protection is a serious matter in our community, and the duty to report should not be taken lightly. Just as many service providers do not know very much about the role of child protection agencies, most members of the public also do not know very much about MCFD. The Ministry has done a poor job in educating the public about its mandate in the community. Most people believe that all they do is take children away from parents that hurt them. The Ministry can provide resources and help parents to be better parents. They do not wish to remove children unless the child is in danger from the adults who are supposed to be taking care of them. A fear that many parents have is that their child could be taken away from them, and this can be a devastating experience for both parents and children. Most people know that the Ministry has strong legal representation, and they may not know their own legal rights.

Women also have justifiable reasons to feel scared and untrusting of MCFD. They have heard of situations in which children were removed from their homes for long periods of time, and relationships were affected. They do not want to be involved with MCFD if it is going to be a long and emotionally painful experience. The intervention of MCFD can also put women at greater risk from abusive partners, who may blame them for the MCFD involvement. As a result of MCFD investigation and concern, women may feel depressed, or use substances to minimize fear and sadness. Many further issues may surface as a result of the Ministry involvement and it is understandable that many women feel like they are losing control of their lives or at least their parenting when MCFD is contacted. It is important to continue to work with a woman in the process of reporting, investigation and intervention to encourage her own advocacy, to focus her on her strengths and to inform her of her rights.

4.9.4 Collaboration As A Means Of Supporting A Woman's Rights

The relationship between the Ministry and the client does not have to be adversarial. The two parties can work together to provide the best plan for the child, because the safety and protection of the child, along with his/her mother, is paramount. The social worker is often concerned about the entire family.

If the worker can help the client to have a better understanding of the Ministry and help her to work with them, the process will not feel as daunting or isolating. Women who have no support from friends, family or

service providers find the task of going through the process of court dates and hearings very stressful. If a child has been removed from the home, there are ways in which parents can work with the Ministry to have the child returned to them. Again, this would be an important time for the worker to support the woman.

Fostering healthy working relationships between the anti-violence worker and the Ministry is useful in being a strong advocate for the client. The social worker does not want to be perceived as the enemy and the anti-violence worker does not want to be seen as being against the importance of the work that the social worker is doing. Having strong working relationships with the social worker will allow her to have access to decisions and interventions, which in turn benefits the client. It also shows the social worker that the mother and worker are discussing the needs of the family and are actively working to keep the children safe. For more information on establishing a collaborative relationship see the sub-section Advocating for a woman's access to mental health services, in the Treatment Issues with Mental Health and Substance Use Problems section.

The relationship between the client and worker does not have to end because there are child protection issues to address. This can be a very helpful time for the counsellor to work with many different aspects of the client's life. The key to maintaining and strengthening this relationship with the client is:

- to be honest about everything that is going on
- to help her understand the role of MCFD
- to empower her in her rights and responsibilities as a parent
- to encourage her to work with the Ministry rather than against them

Most parents try to do the best they can. Some make decisions that they later learn are not right, and they regret their choices. Others struggle with their ability to parent, and are prepared to face the consequences and learn from their mistakes. Regardless of the parent and their experience, the involvement with the Ministry can be made more manageable if the worker can work with them in whatever ways are most helpful. This may include:

- not judging the client for her mistakes
- seeing the mother as the expert on her own life
- finding resources like parenting classes
- providing emotional support while she goes through this process

At the end of the day, the safety of the child as well as the mother is the most important concern, but being able to assist a woman as she tries to be a better parent to that child can be equally as important.¹

(Endnotes)

1 The information provided is based on my 14 years of working with families, women and children. I do not consider myself an expert in the mental health or child protection fields. My writing is based on the invaluable experiences that I have had working with people, and it is from those experiences that I share with the reader my ideas. I am also influenced by my own lived experience of being a female, a woman of colour and a mother.