STUDENT MATERIAL

TO

VICTIM EMPOWERMENT: BRIDGING THE SYSTEMS MENTAL HEALTH AND VICTIM SERVICE PROVIDERS

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INTRODUCTION

Although the world is full of suffering, it is also full of the overcoming of it.
Helen Keller

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Introduction

"There is nothing more isolating than the pain of violation. It forces victims to question themselves and their world because it destroys two essential beliefs: (1) their sense of trust and (2) their sense of control over their lives. After the crime is over, victims begin to struggle with their reactions...they are often overcome with fear, anger, guilt and shame. They may feel contaminated and unworthy of help. Their relationships with family and friends can be seriously disrupted, and if they become involved with the police and the courts, they may come to believe that no one understands or cares about what has happened to them." (*The Crime Victim's Book*, Bard and Sangrey, 1986)

A victim of a serious personal crime as well as significant others, family members and friends, go through a difficult adjustment period, often experiencing the impact of the crime in varying degrees for the remainder of their lives.

Purpose

This curriculum and participant's resource manual were produced with a grant from the Office for Victims of Crime. The resource manual contains a collection of articles and information written from either a mental health or a victim services perspective. Because these perspectives are not always in agreement, there may be conflicting points of view which participants can use as discussion starters.

Individuals with diverse backgrounds, expertise and experience in victim services and mental health served as an advisory panel and assisted the Pennsylvania Coalition Against Rape with the development of this curriculum. The panel members of *Victim Empowerment: Bridging the Systems - Mental Health and Victim Services Providers* saw the project as essential and vital to the provision of quality support services and treatment for victims of crime and their significant others. They also saw this project as an opportunity to develop a collaborative systems approach to victim services between mental health and victim services providers.

The Pennsylvania Coalition Against Rape wishes to thank the advisory panel members for their time and expertise in the development of the curriculum outline.

Advisory Panel Members

Introduction

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Introduction

Advisory Panel Recommendations

For this curriculum to be utilized to its maximum potential, the panel made the following recommendations:

- The training curriculum will be provided to individuals only as part of a training program.
- A 'train the trainers' program will be conducted to ensure that the manual and its information are used consistently.
- Trained teams, representative of victim services and mental health professionals, will be sought.
- Trainees or participants will be selected with the advice and input of local community leaders.
- Trainees are to be representative of the victim services and mental health fields.
- Trainees are to be motivated individuals who are committed to change and willing to promote change in their respective communities.
- Funding and resources should be available to address the recommendations as stated.

Core Beliefs and Concepts
The material in this manual has been selected based on these core beliefs:

- We need a violence-free culture
- Victims should be the focus of the system(s)
- The victim empowerment as the model includes:

  Victims
  - Having the right to be believed and owning their stories
  - Being in control of the healing process

  Service Providers
  - Acknowledging the rights and responsibilities of victims
  - Respecting the choices of victims
  - Providing victims with options for choices
  - Avoiding inappropriate labeling of victims
  - Working collaboratively with other systems to support victims

- Victims are not to blame for their victimization
- People are responsible for the effects of their behavior
- The trauma of victimization is not mental illness but victimization is trauma and needs to be addressed
- Confidentiality is important

Why Build a Bridge?

A mental health professional who has not received any training on the unique emotional and psychological issues of trauma may not be able to appropriately respond to a crime victim or even make a suitable referral. For example, to someone not trained in victimization issues, a burglary might be seen as a minor loss of possessions, something to be dealt with quickly by the police and insurance company, with perhaps the added security of new locks. However, to burglary victims, there has been a violation of an extension of themselves. For many, the loss or damage to money and/or possessions are not nearly as harmful as the intrusion into the privacy of the home, the place where people are supposed to feel safe.

Victim Empowerment

Introduction

Historically, mental health counselors, psychologists, and psychiatrists have not received extensive training in victimization issues. In a recent survey by the Mental Health Association of more that 175 mental health professionals in Berks County, Pennsylvania:

- Less than one-third of the 130 respondents were willing to and/or had experience in working with victims of violent crime
- Only a handful indicated they had more than limited experience
- There were very few mental health professionals who indicated knowledge of sexual assault issues

At the Erie County Rape Crisis Center in Pennsylvania:

- Approximately 25% of its clients, who were victims of sexual assault/abuse or victims of other crimes, were also receiving services at one or more mental health service providers

It is important to note that not all crime victims require treatment by a mental health professional. If a victim is regarded as having functioned adequately or "normally" prior to the victimization, then the crime is seen as a crisis or a disruption to the life of the victim. While a victim's response may not "look" normal to those who do not have an understanding of trauma issues, it could be a normal response to an abnormal event.

Victim service providers use crisis intervention techniques, including empowerment counseling, to restore the victims to their previous level of functioning. They address issues unique to the victimization such as:

- Safety
- Body boundaries
- Self-esteem
- Regaining power and control
- Re-establishing trusting relationships

Studies such as Rape in America (NVC, 1992) show that many victims do not successfully regain control over their lives after their victimization. Although many crime victim programs provide victims with long term counseling, including support groups, numerous individuals are concurrently and appropriately seen by mental health professionals. For those programs that are limited to crisis services and for those clients

who should be referred for further treatment for mental health issues, victim services providers must learn when and where to refer clients:

- Victim services counselors must learn the warning signals to make referrals, such as those offered by the American Psychiatric Association, which include:
  - Prolonged depression or apathy
  - Suicidal ideations
  - Substance abuse
  - Inability to cope with daily activities after an appropriate period of time

- Victim programs must develop referral lists of mental health providers who understand trauma and victimization issues, are willing to accept clients who do not have insurance coverage or funds and are available without prolonged waiting periods.

- Through coordinated appropriate releases with mental health practitioners, victim services staff can continue to address the victimization needs such as court accompaniment, and specific victimization counseling.

Ten years ago, the American Psychological Association Task Force on the Victims of Crime and Violence, chaired by Morton Bard, Ph.D., made the following recommendations:

- Psychologists involved in service delivery should acquire specific, identifiable skills in direct intervention with victims.

- More psychologists should acquire specialized consultative skills to increase the capacity of indigenous workers to help victims.

- More psychologists should become involved in initiating and evaluating changes in the criminal justice system to ameliorate the problems victims experience in that system.

- More psychologists who are prepared to do so should actually provide service directly to victims, to indigenous helping systems, and in the criminal justice system.

- Psychologists should be more involved in gaining knowledge about the victim

experience and about helpful intervention for victims.

- There should be greater public awareness about the mental health needs of victims and the roles psychologists can serve in helping victims.

- The APA should endorse laws and legal arrangements that facilitate the realization of victims' interests and encourage the formal evaluation of these arrangements.

Dr. Bard made recommendations for the mental health community in *The Crime Victim's Book*, which include:

- Establishing training programs that enable practitioners to treat crime victims and their families

- Establishing and maintaining direct liaisons with victim services agencies

These comments were echoed by Shelly Neiderbaum, one of the founders of the International Association of Trauma Counselors, Inc., at the National Organization for Victim Assistance 1995 Conference.

UNDERSTANDING AND RESPONDING

TO THE TRAUMA

OF

VICTIMIZATION

To experience anguish and anxiety in the face of the perils that threaten us is a healthy reaction. Far from being crazy, the pain is testimony to the unity of life. The deep interconnections that relate us to other beings.

Joanna Macy

Understanding and Responding to the Trauma of Victimization

Trauma of Victimization

Victims of personal crimes are dealt a severe blow to their view of reality:

- They have been deliberately violated by another human being
- The crimes may range from having a pocket picked to murder
- The issues involved with each type of crime are unique
- The personal abilities of victims to deal with the specific type of crime are also unique

Extent of Victimization

- Every 2 seconds a property crime is committed
- Every 15 seconds a woman is battered
- Every 46 seconds someone is robbed
- Every minute 1.5 adult women are raped
- Every minute approximately 6 American children are reported as abused and neglected
- Every 21 minutes someone is murdered
- Every day 55 Americans are killed in alcohol-related traffic crashes (from National Victim Center 1994 Crime Clock)

Stages of Crisis

Most victims experience a common series of emotional reactions. This parallels the grief process outlined by Elisabeth Kubler-Ross in *On Death and Dying*, or rape trauma syndrome described by Ann Burgess in *Rape and its Victims*. It consists of three basic stages:

STAGE ONE: **Crisis/Acute Stage**

Denial - "This cant' be happening to me, it must be a dream."
"I feel like an observer, watching and reliving someone else's experience."

STAGE TWO: **Intermediate Stage** (24 hours to 6 weeks):

A series of different emotions intrude and fade with varying intensity: fear, anger, guilt, frustration, embarrassment. They are often accompanied by disruptions in

eating/sleeping patterns and a change in lifestyle. Victims can fluctuate between feeling able to cope to feeling out of control. One minute they will blame themselves and the next rage against the individual(s) who harmed them.

STAGE THREE: **Reintegration** (one week to one year):
Victims resume normal life. The intrusive memories lessen and the victims integrate the crime into their total life experiences. As one victim commented, "I have it in perspective now and don't think of it very often anymore."

While these are the primary stages of crisis, victims react differently. Many victims are amazingly resilient and can cope easily in the aftermath of a crime. In some cases, it takes longer for the bruises to heal than the emotional scars. Much depends on how the crime is perceived by the victim, family and friends, and the community. Victims' reactions do not take place in an isolated environment, but are influenced by other circumstances.

Identifying and Assessing Signs of Crisis*

Crisis Invervention

With the gift of listening comes the gift of healing, because listening to your brothers or sisters until they have said the last words in their hearts is consoling. Someone has said that it is possible "to listen a person's soul into existence." I like that.
-Catherine de Hueck Doherty

Overview

Natural caregivers have known for centuries the value of listening with great care and little judgment to a person's sorrow and pain. Though some people have a natural gift for providing that kind of help, most people need some assistance in learning the basics of crisis intervention -- it is, to a degree, "contra-instinctual" -- and everyone can, with study, improve their crisis intervention skills.

In the aftermath of a catastrophe, most victims must deal with the physical and emotional shockwaves of the event but also, in short order, with the sense of helplessness,

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powerlessness, and a loss of control.

For many victims, the physical and emotional reactions which describe crisis are not severe, and recede after a few hours or days. For others, the crisis is put on hold while they mobilize their survival skills, and only days, even years, later, are they slapped with a sense of the enormity of the event, now vividly remembered. Even victims who do not develop the symptoms of long-term stress reactions face the risk that certain "triggers" will reproduce the old feelings of panic, helplessness, anger, and the like.

"Crisis Intervention" is obviously a humane effort to reduce the severity of a victim's crisis, to help the victim win as much mastery over the crisis experience as possible. To understand the potential benefits of crisis intervention, it is worth emphasizing that these are a battery of skills that victim advocates should possess -- but so should others whose professional work brings them into contact with victims in crisis.

A common response in the shock of the moment is for the victim to retreat into a childlike state, and when the immediate danger is passed, to turn to someone nearby who is perceived as an authority figure for help-- a law enforcement officer, teacher, nurse, a friend, anyone who offers a sense of "parental" comfort. Anyone whose job constantly puts them in that role discovers how "accessible" the victim is at the moment. The helper is now invested with extraordinary influence in the life of the victim in crisis. In these circumstances, the helper is a crisis intervenor -- perhaps a gifted one, perhaps one whose talents have been forged by experience, or far more likely, a conscientious professional with no training or skills in how to interact with people in crisis, to the detriment of both the victim and the professional.

"Crisis" encompasses a number of intense, tumultuous emotions; it can be a continuing condition, or alternatively flare and recede; any stressful, post-crime event, such as going to a battered women's shelter, or to a lineup, or to a trial, may put the victim back into crisis. While there are no predictors about who will experience crisis, or when the onset will be, or how severe it will be in the intensity or duration, a working presumption for most crisis intervenors is that the sooner the service is offered, the better. Indeed, there is a conviction among many practitioners that on-scene intervention, when the victim is in the early stages of distress, may prove to prevent or greatly reduce the crisis symptoms that might otherwise afflict the victim.

Techniques

A. Safety and Security

Understanding and Responding to the Trauma of Victimization

1. The first concern of any crisis intervenor should be for the physical safety of the victim. Until it is clear that the victim is not physically in danger or in need of emergency medical aid, other issues should be put aside. This is not always immediately obvious. Victims who are in physical shock may be unaware of the injuries they have already sustained or the dangers they still face.

   For the crisis intervenor who is responding to a telephone crisis call, the question should be posed immediately, "Are you safe now?" Intervenors who are doing on-scene or face-to-face intervention should ask victims if they are physically harmed. That question alone may cause the victim to become aware of a previously undiscovered injury.

2. A parallel concern should be whether the victim *feels* safe. The victim may not feel safe in the following circumstances:

   - The victim can see and hear the assailant being interviewed by law enforcement officers.
   - The victim is being interviewed in the same area where the attack took place.
   - The victim is not given time to replace torn clothes.
   - The victim is cold and uncomfortable.
   - The assailant has not been apprehended and he has threatened to return.

   Any of these may make the victim feel unsafe even if there are law enforcement officers present. In the aftermath of Edmond, Oklahoma, post office mass murders in 1986, one of the survivors of the attack said that he would not feel safe until the assailant, Patrick Sherrill, whose final killing was of himself, was physically in his grave.

3. A priority for some victims and survivors is the safety of others as well. If a couple has been robbed in a street crime, each may be more worried for the other person than himself or herself. Parents are often more concerned about the safety of their children than their own.

4. Survivors of victims of homicide may not focus on safety but rather seek a sense of security through the provision of privacy and nurturing. Their anguish and grief can be made more painful if there are unfamiliar and unwanted witnesses to their sorrow.

   They, too, will suffer feelings of helplessness and powerlessness. The shock

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of the arbitrary death of a loved one is usually not assimilated immediately and survivors may not understand questions or directives given to them. One mother did not realize that she had said yes when she was asked if she wanted to identify the body of her son. When she was taken to the morgue, she became hysterical and distraught because she was not properly prepared.

5. All victims and survivors need to know that their reactions, their comments, and their pain will be kept confidential. If confidentiality is limited by law or policy, those limits should be clearly explained.

6. Security is also promoted when victims and survivors are given opportunities to regain control of events. They cannot undo the crime or the death of loved ones, but there may be opportunities for them to take charge of things that happen in the immediate aftermath.

7. Hints for Helping.

   a. Make sure the victims/survivors feel safe or secure at this point in time.

   - Sit down to talk.
   - Ask the victims/survivors where they would feel safest when you talk to them, and move to that location.
   - If it is true, reassure them with the words "You are safe now."
   - Identify yourself and your agency clearly, and explain your standards of confidentiality. You might say, "Our program's standards require me to keep all information that you tell me confidential unless you give your permission to me to release it..."
   - If possible, keep media away from victims/survivors or help them in responding to media questions. If the case involves a sensational crime and there are media representatives approaching the survivors, try to ensure that the victims/survivors understand that they do not have to answer questions unless they want to, and under circumstances of their own choosing.
   - If they have loved ones about whom they are concerned, try to find out as much information as possible about the safety of the loved ones. For instance, a mother who has been a victim on the way home from work might not be as worried about the victimization as the safety of a child who is home alone awaiting her arrival.
   - If victims are to be interviewed by law enforcement officers, try to ensure that they understand questions by asking them to repeat the question back to the interviewer.

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Understanding and Responding to the Trauma of Victimization

- Provide victims with information that may help to assure them of their safety. For instance, if they have been survivors of a massacre, it may help if they are assured that the gunman is dead, or that he has been apprehended.
- If they are not safe, keep them informed about the extent of additional threat. For instance, if the gunman is still at large, try to get information about his whereabouts. If possible, find them an alternative location at which to stay for a few hours or a few days. In the aftermath of the serial killings of five co-eds in Gainsville, Florida, the victim/witness program and the community arranged for students to sleep together in dormitory-like conditions in a large auditorium surrounded by guards, all to restore a sense of safety.
- Give victim permission to express any reactions and respond non-judgmentally. Say: "You have a right to be upset over this tragedy, so don't be afraid to tell me what you are thinking."

b. Respond to the need for nurturing -- but be wary of becoming a "rescuer" on whom the victim becomes dependent. The "rescuer" who ends up months later making decisions for the victim has subverted the primary goal of crisis intervention; that is, to help the victim restore control over his or her life.

- An apt analogy for the role of the crisis intervenor at this stage is as follows: when a person breaks his leg, a doctor sets it and puts it in a cast. While it heals, the patient uses crutches to get around, and when the cast is removed, the leg still needs exercise and care to become strong again. When someone survives a violent crime or the death of a loved one, they survive with a fractured heart. The crisis intervenor becomes like the doctor. The initial intervention helps the survivor by protecting that heart as much as possible against further harm. Later, the crisis intervenor provides support, understanding, and a few crutches while the survivor begins the long process of healing a broken heart.

c. Help survivors to re-establish a sense of control over the small things, then the larger ones, in their lives.

- While it is important to assist survivors with practical activities, it is also important to allow them to make decisions for themselves and to take an active role in planning their future.
- The crisis intervenor initially can offer survivors a sense of control by asking them simple questions involving choices that are easily made.

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For instance, "What name would you like me to use in talking with you?" "Where would you like to sit while we talk?" "Would you like a glass of water?"

- Often the recovery of a physical object that is important to the survivor helps to re-establish a sense of control. For instance, after an arson burned down much of one family's home, the entire family was strengthened when a law enforcement officer found their cat in the bushes nearby. The family had thought the cat had died in the fire.

B. Ventilation and Validation

1. Ventilation refers to the process of allowing the survivors to "tell their story." While the idea of "telling your story" seems a simple concept, the process is not easy. Victims need to tell their story over and over again. The repetitive process is a way of putting the pieces together and cognitively organizing the event so that it can be integrated into the survivor's life. The first memory of the event is likely to be narrowly focused on, say, a particular sensory perception or a particular activity that occurred during the event. Victims usually see the criminal attack with tunnel vision. They know intuitively that other things are happening around them, but they may focus on an assailant's knife, their struggle to get away, their first impression of a burglarized room.

   As time goes by, memory will reveal other parts of the event. These bits of memory will come back in dreams, intrusive thoughts, and simply during the story-telling process. The victimization story will probably change over time as they learn new things and use the new information to reorganize their memories.

   For example, a victim who reported a burglary first told the crisis intervenor that he heard a noise and he went downstairs to see what was wrong, finding a burglar in his front room. The burglar grabbed something and struck him in the stomach before running out the front door. There was a crash and then everything went silent.

   When the man repeated the story the second time, he said that he remembered that it was just a noise, but it sounded like some whispering and rustling. On a later telling, he remembered that when he came downstairs, he saw a brief flash of light toward the back of the house.

   Upon investigation, it was discovered that there had probably been two

burglars and one had exited through the kitchen window in the rear of the house.

This process of reconstructing a story results in inconsistent or contradictory stories, which undermine an investigation or a prosecution. However, from a crisis intervention perspective, it is perfectly normal for the process of ventilation to reveal a more complete story over time. Realistically, a victim will tell his story over and over again, with or without a crisis intervenor, in order to reconstruct the event, so that the story will often change anyway. The difference is that the crisis intervenor will provide a sounding board for the victim's distress as the review process unfolds.

For victims, the replaying of the story over again helps them get control of the real story. The "real" story is not only the recitation of the event itself, but usually includes the story of various incidents in the immediate aftermath; the story of ongoing traumatic incidents related to the crime; the story of families' or friends' involvement in the event; and so forth. Each of these stories must be integrated into the victim's final mental recording of the event.

2. A part of the ventilation process is finding words or other ways that will give expression to experiences and reaction. In this aspect, ventilation is often culturally-specific. Some cultures may express their reactions through physical or various artistic forms rather than words. In most of the United States, words are the most comfortable form of expression.

   The power found in putting words to feelings and facts is tremendous. There is often a depth of emotion in telling another person that a loved one has died, even in finding the name of the loved one. The power is also illustrated in the release that many victims find when an intervenor responds to their ventilation with a word that expresses what victims feel. For instance, victims may feel intense anger towards an assailant and find the word "anger" insignificant to express their intensity. When an intervenor offers a word like "outrage" or "fury" to describe their feelings, victims often feel a sense of liberation -- a sense of permission to feel such intense emotions.

   The exact words to describe events and experiences are often vital. For example, Mothers Against Drunk Driving (MADD) is adamant about the importance of calling the collision of a car driven by someone drunk a drunk-driving "crash," a term often used to describe a mechanical or human error.

3. Validation is a process through which the crisis intervenor makes it clear that

most reactions to horrific events are "normal."

a. Validation should be content-specific. Example: rather than saying "I can't imagine how upset you are," it is preferable to say "I can't imagine how upset you are about your son's death in the car crash."

b. Care should be taken in the words that are used to validate. For instance, many survivors do not want to hear their reactions are “normal reactions to an abnormal situation" - a common summation of what crisis and trauma produce - because survivors want to have their experience validated as unique. Telling them that their reactions are "not common" seems to be more effective.

c. Where possible, repetition of the actual phrases that the survivors use to describe experiences is useful. Example, if someone says, "I can't sleep at night, I am so afraid that someone will break in and kill me and my family," an appropriate response would be, "It's not unusual for you to be afraid after such a terrifying experience. If you can't sleep at night, that only shows how afraid you are."

4. The focus of validation should be that most reactions of anger, fear, frustration, guilt, and grief do not mean that the victim is abnormal, immoral, or a bad person. They reflect a pattern of human distress in reaction to a unique criminal attack.

a. While most reactions are normal, there are some people with pre-existing mental health problems who have harmful reactions. There are also some who react to personal disasters in a dangerous way - to themselves or others. In the aftermath of crisis, the intervenor should always be alert to any words or other signs of suicidal thoughts or threatening behavior towards specific individuals. If these arise, seek immediate professional help - a mental health professional, a suicide hotline, even a law enforcement agency if there is an imminent threat to someone else.

b. While most reactions are normal, most people have not experienced such intense feelings, so they think they are "going crazy." Survivors should be reassured that while the crisis has thrown their lives into chaos, they are not, as a consequence, crazy.

5. Hints for Helping. The following introductory questions will help the victim focus on the crime in an objective way. It will help the victim impose an order

on the event and begin to take control of the story. It may help to ask the victim to recall that day from the beginning, so that the "normal" parts become part of the crisis story.

a. Ask the victim to describe the event.

b. Ask the victim to describe where he or she was at the time of the crime, who he or she was with, and what he or she saw, heard, touched, said, or did.

c. Ask the victim to describe his or her reactions and responses. As the victim begins the description, remember to validate the reactions and responses. If she says: "I remember turning stone cold when I felt the hand on my back and a tug at my purse," say, "Some people have called that a `frozen fright' reaction."

d. Ask the victim to describe what has happened since the crime, including contact with family members, friends, the criminal justice system, and so on. Responses to this question will help reveal whether the victim has suffered additional indignities as a result of the crime or whether the victim has been treated with dignity and compassion.

e. Ask the victim to describe other reactions he or she has experienced up to now. Again, validate reactions.

f. Let the victim talk for as long as you can. If you are running out of time, give the victim at least a fifteen-minute warning, such as, "Mrs. Jones, I really want to hear more about your experience and reactions, but I have to leave in about fifteen minutes. If we don't finish up this part by then, I want to do that tomorrow, at a time that is good for you. If I don't hear from you, I'll give you a call, if that's okay."

g. Don't assume anything - even the apparent pattern of the crisis reaction is suspect. So, for example, the victim's controlled calm of the moment may yield to tears in a few minutes, or a few weeks. Indeed, if the victim is experiencing crisis, it is safe to bet that his or her reactions will take new form over time.

h. Don't say things like: *I understand.*
It sounds like...
I'm glad you can share those feelings.

Understanding and Responding to the Trauma of Victimization

	You're lucky that... *It'll take some time but you'll get over it.* *I can imagine how you feel.* *Don't worry, it's going to be all right.* *Try to be strong for your children.* *Calm down and try to relax.*
Do say things like:	*You are safe now (if true).* *I'm glad you're here with me now.* *I'm glad you're talking with me now.* *I am sorry it happened.* *It wasn't your fault (if there was no attributable blame to the victim).* *Your reaction is not an uncommon response to such a terrible thing.* *It must have been really upsetting to see [hear, feel, smell, touch] that.* *I can't imagine how terrible you are feeling.* *You are not going crazy.* *Things may never be the same, but they can get better.*

To improve communication with the victim, avoid words like:

Feelings - although this chapter is concerned with victims' feelings, in practice it is better to stick with the word "reactions" to describe "feelings." Many people are uncomfortable with being asked to talk about their feelings or emotions.

Share or sharing - ask people to tell you about their experiences. Don't ask them to "share" those experiences or thank them for "sharing." No one can literally share another person's experience, even if they have suffered through the same event. Many people resent the presumption implicit in this term, or the "social work" connotation it carries.

Client or Victim or Survivor - when talking to or about a person for whom you are providing crisis intervention, use the victim's preferred name.

Incident or Event - when referring to the crime or the criminal attack. While such words may be used in other settings, they are inappropriate in talking with the person who has survived such an "event."

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Alleged - when referring to a victim. Let the lawyers speak of alleged victims and offenders if they need to. Victim advocates should assume that people who describe themselves that way are what they say - victims of crime.

C. Prediction and Preparation

1. One of the potent needs that most victims have is for information about the crime and what will happen next in their lives. Remember, their lives have typically been thrown into chaos and they feel out of control. A way to regain control is to know what has happened and what will happen - when, where, how.

2. The information that is most important to victims is practical information. The following are examples. Note that some topics may raise scary possibilities that the victim has not even considered; the intervenor may tactfully touch on such issues or defer them. However, never duck any unpleasant surprise if there is reason to believe that the victim will find out about it soon.

    a. Will the victim have to relocate? Many burglary victims need to move temporarily because their homes are no longer secure. If relocation is necessary or recommended, what are the victim's options?

    b. Does the victim have adequate financial resources to pay for any immediate needs caused by the crime? The robbery victim may not have money to pay for food or rent, even if a compensation program may reimburse a victim at a later date, the need for immediate money is sometimes overwhelming.

    c. What legal issues confront the victim? Will the case be processed in the criminal justice system? Will there be an investigation? What are the chances that there will be an arrest - and then prosecution, trial, conviction, and sentencing? Does the victim have civil litigation options? Might it be feasible for the victim to sue the offender or a third party who might be held responsible for factors leading up to the attack? Note that honest answers and estimates are essential; to the victim of a "cold" burglary with no immediate suspects, the bad news is that fewer than one such case in fifty results in an arrest in most jurisdictions - and giving a rosier picture will undermine your future credibility. By the same token, there may be many questions that arise which are beyond the intervenor's expertise; note them, and help the victim to get expert answers.

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d. What immediate medical concerns face the victim? An injured victim needs information about the extent of those injuries. A sexual assault victim may need information to make informed decisions on testing for pregnancy or sexually-transmitted diseases, including HIV. The survivor of a victim of homicide or catastrophic injury may need detailed information about the cause of death or extent of injuries.

e. What will be expected of the survivors of a homicide victim in the immediate future? Will they be asked to identify the body? If so, what is the condition of the body? Is there a need to address immediately funeral considerations? (Some religions call for immediate burial.) Do the survivors know their loved one's body will be given an autopsy?

f. What does the victim need to know about the media? As indicated above, if the case is sensational or has a "newsworthy" face to it, it is likely that there will be media coverage. Does the victim know his or her rights? Is the victim prepared for a full media intrusion? Has the victim been warned that what appears in the media may not have any relation to the truth as he or she has experienced it?

3. The second priority is the information on possible or likely emotional reactions that the victims might face over the next day or two, and over the next six months or so - emphasizing that there is no particular timetable when victims can expect to experience crisis reactions, or which of the intense emotions may surface. In many ways, this review will become as important as anything else they learn. In the initial stages of dealing with the crime, practical issues are their priority. Some of the emotional concerns that should be outlined, however, are the following:

a. Immediate physical and mental reactions to crisis. These reactions may include inability to sleep, lack of appetite, anxiety, numbness, estrangement from the world, a sense of isolation, anger, fear, frustration, grief, and an inability to concentrate.

b. Long-term physical and mental reactions. These reactions may include intrusive thoughts, nightmares, terror attacks, continued sense of isolation, inability to communicate with others, sleep disturbances, depression, inability to feel emotion, disturbance of sexual activity, startle reactions, irritability, lack of concentration, and so forth.

c. Reactions of significant others. While some friends or family members

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serve as the most important source of emotional support for victims, many cause as much harm as good. Three common reactions that may cause victims distress are: over-protectiveness; excessive anger and blame directed toward the victim; and an unwillingness to talk about or listen to stories of the crime.

d. Victims should expect that everyday events may trigger crisis reactions similar to the ones they suffered when the crime occurred. Thus, the birthday of the son who was murdered may trigger overwhelming feelings of grief and anger about the murder. A sunset of a particular shade and color may trigger a panic attack in a victim who was robbed during such a sunset. The smell of alcohol on the breath of a young man may trigger an outburst of rage in a young woman who had been raped by a man who had been drinking.

4. In addition to needing predictable information, victims need assistance in preparing for ways in which they can deal with the practical and emotional future. The following are some hints for helping.

a. Take one day at a time. Suggest that the victim plan each day's activities around needed practical tasks. Help the victim list the tasks that need to be done and set a goal for accomplishing a certain number each day. Victims who have been severely traumatized may want to check in with you after each day to report their progress and to receive positive feedback on any successes.

b. Problem-solving. Show the victim how to use problem-solving techniques to address the overwhelming problems that he might face. Suggest that the victim list the three most important problems confronting him for the next day. After he makes his list, have him analyze whether all three really need to be done in the next twenty-four hours. If he thinks so, ask him to sort the list in priority order. Take the first problem he has listed and ask him to think about all the possible ways he might deal with the problem. After he has discussed such ideas, ask him to choose the option that he thinks is most feasible.

Example: Jim is a robbery victim. The robber stole his wallet and the contents of his pockets, which included all of his cash, his bank card, his driver's license, his car and apartment keys, and a pocket watch. Jim is panicky because it's 9 at night and he doesn't have any money

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and doesn't know how to get home. Even if he is able to get there, he doesn't have keys to get into his apartment or to drive to work in the morning.

You ask Jim to list his three biggest problems. He says: getting home, getting in his apartment, and getting to work in the morning, in that priority order. You ask him to think of all the possible ways he might be able to get home. After some thought, he decides that he can borrow a quarter from you and call a friend to come get him. He then realizes that his friend would probably let him stay at his house overnight, if needed. He also realizes, as he is thinking, that he might be able to call his landlord from his friend's house and arrange to get into his apartment. As he begins to think calmly and carefully about the problem he remembers he has an extra set of keys to both his apartment and his car at home... and so the problem-solving begins and may continue.

c. Talk and write about the event. Suggest to victims that they use audiotapes or write a journal to tell their unfolding stories. Even if no one else sees or hears these stories, it is a way of expressing oneself and a way of processing thoughts.

d. Plan time for memories and memorials. It can be predicted that certain things will be trigger events for future crisis reactions. Urge victims to try to think through what those trigger events might be and allow themselves time to deal with those reactions. For example, a woman who had been sexually assaulted on October 14 routinely took that day off from work to do something nice for herself and to think about her pain.

e. Encourage victims to identify a friend or family member on whom they can rely for support during times when they must confront practical problems. If they are able to name that person, suggest that they call and explain their need for support and help. If this is done in advance, it makes it easier to request certain help when the time comes.

f. Good nutrition, adequate sleep, and moderate exercise can significantly help victims survive times of crisis. That underestimated triad is, in fact, the basis for virtually all stress reduction programs. Help victims set up their own regular routine of health. At first it may be difficult, but if they keep trying they will readily realize some benefits.

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Understanding and Responding to the Trauma of Victimization

... Charles Dickens said, "No one is useless in this world who lightens the burdens of others."

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Secondary Victimization*

After the trauma of a crime, many report being victimized by the very systems that were designed to help them. The media, health services and criminal justice system can respond to victims of crime in ways that make them feel traumatized again. A counselor can help to reduce the chances of secondary victimization by helping victims to understand their rights.

Crime Victims' Rights

While the American criminal justice system is primarily modeled after the English system, there is an important difference in criminal prosecutions. Historically, criminal prosecutions in England were private actions brought by the victim or a representative of the victim. In the American tradition, a crime is deemed to have been committed against the state or against society as a whole. An unfortunate outcome of this is the victim's assignment as a witness. Since the crime is viewed as being committed against the state, it is the state's job and right to prosecute. In criminal cases, it is not the victim who decides if the case will go to court. The victim has little or no control over the process of bringing the offender to justice.

In recent years, America's victims' rights movement has advocated to up-grade the victim's role in the criminal justice process. It has sought to balance the rights of victims and the accused. During the past two decades, all states have passed laws affirming the rights of crime victims. Almost every state has enacted "victims' bills of rights." A quarter of the states have passed constitutional amendments for victims' rights.

Today, victims are frequently categorized - sexual assault victims, domestic violence victims, child abuse or neglect victims, elderly victims of abuse, victims with disabilities, victims of hate-motivated crimes, and even Good Samaritans. Many states have included surviving family members of homicide victims in their definition of "victim." These groups often have rights and remedies that are unique and distinct, such as protection from abuse orders for domestic violence victims, videotaped testimony and testimonial aids for child victims, and protective services for elderly victims.

* from Nation Victim Center INFOLINK Series

Understanding and Responding to the Trauma of Victimization

All states have rights for crime victims, but the scope varies greatly from state to state. Victims' rights can include:

- The right to attend and/or participate in criminal justice proceedings
- The right to notification of the stages/proceedings in the criminal process and of other legal remedies
- Protection from intimidation and harassment
- The right to confidentiality of records
- Speedy trial provisions
- The right to prompt return of the victim's personal property seized as evidence from offenders
- The availability of offenders' profits from the sale of the stories of their crimes
- Victim compensation and restitution

Victim Impact Statements*

Courts in every state are permitted to consider or even to request a victim impact statement. These statements provide a way for those deciding a case to factor in the human cost of the crime and for victims to participate in the criminal justice process.

Almost all states provide for victim input at sentencing. Impact statements can be mandated by law, or left to the judges' discretion. Most victim impact statements normally written, and become part of the pre-sentence report. They may be drafted by the official preparing the pre-sentence report, the victim, or survivors of the victim, depending on the law. In some states, the parent or guardian of a minor or incompetent victim can prepare the statement. The *Child Protection Act of 1990* permits child victims of Federal crimes to submit victim impact statements in ways that are "commensurate with their age and cognitive development," which could include drawings, models, etc.

A state may allow written or oral statements at sentencing. The oral statements may be made by the victim, survivors of a victim, or in some states, a representative of the victim or victim's estate.

Victim impact statements can include the financial, physical, psychological or emotional harm that the victim or victim's family suffered. State law might specify what can be

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included in the statement, or it may simply permit a "description of the impact of the offense." Victims may be permitted to state what sentence they wish the offender to receive or voice their opinions about the proposed sentences. In more than half of the states, victims can submit impact statements even if the offender was sentenced prior to the passage of an impact statement law. The majority of states also permit victim input at the parole hearing.

In 1990, the California legislature passed a law which permits the use of *videotaped* victim impact statements at parole release hearings. Acknowledging that many victims are unable to travel to parole release hearings, more states are permitting video impact statements. Some states are permitting the use of *audiotaped* victim impact statements for the same reasons.

Victim impact statements that are submitted to the court at the time of sentencing should also be included in an offender's file. This assists the paroling authorities in understanding how the crime affected the victim(s) soon after it occurred, rather than its impact at the time(s) of parole release hearings. In over half of the states, the original victim impact statement is kept on file by corrections authorities, and reviewed as part of the parole process. Many states solicit updated impact statements for parole hearings as well.

Crime Victims and the Media*

In its rush to be the first with the news, the media can often inflict a "second victimization" upon crime victims or survivors. Common complaints that victims have include: interviewing survivors at inappropriate times; filming and photographing gruesome scenes; searching for the "dirt" about the victim; seeking interviews with friends or neighbors', interviewing or photographing child victims; printing victims' names, addresses or places of employment; and scrutinizing victims' past. After a crime, victims are frequently physically and mentally numb. They are confused and disoriented.

A recent study shows that television news directors agree in principle that crime victims have privacy rights and the individual's right to privacy is *not* outweighed by the public's desire to know. However, directors are less likely to adhere to this principle if they know a competitor is going to break the story.

While victims have rights when dealing with the media, many yield to media pressures and answer questions that they would not consider answering under other circumstances. In most cases, there are no legal remedies if his or her rights are violated.

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Understanding and Responding to the Trauma of Victimization

The National Victim Center developed this list of rights for victims:

- To say "no" to an interview
- To select the spokesperson or advocate of the victim's choice
- To select the time and location for media interviews
- To request a specific reporter
- To refuse an interview with a specific reporter even though he or she has granted interviews to other reporters
- To say "no" to an interview even though the victim has previously granted interviews
- To release a written statement through a spokesperson in lieu of an interview
- To exclude children from interviews
- To refrain from answering any questions with which the victim is uncomfortable or that the victim feels are inappropriate
- To avoid a press conference atmosphere and speak to only one reporter at a time
- To demand a correction when inaccurate information is reported
- To ask that offensive photographs or visuals be omitted from airing or publication
- To conduct a television interview using a silhouette or a newspaper interview without having a photograph taken
- To completely give the victim's side of the story related to the victimization
- To refrain from answering reporters' questions during a trial
- To file a formal complaint against a reporter
- To grieve in private

Medical Issues*

Twenty-eight percent of rape victims report some degree of physical injury as a result of the rape (Rape in America, 1992).

Every year, domestic violence results in almost 100,000 days of hospitalizations, almost 30,000 emergency department visits, and almost 40,000 visits to physicians (American Medical Association, 1991).

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Understanding and Responding to the Trauma of Victimization

Every year hospitals spend millions of dollars treating victims -- including victims of physical abuse, homicide, terrorism, aggravated assault, rape and domestic violence. Even though hospital staff see many victims of trauma and in many cases are one of the first to respond to victims, hospitals are frequently understaffed and personnel undertrained to deal effectively with the emotional needs of victims.

Individuals whose physical wounds do not appear to be severe may be forced to sit and wait while others are treated. In some cases the victim and the offender may be brought to the same hospital for treatment. The victim may be forced to be in close proximity to the offender while awaiting or receiving medical treatment.

Staff who deal with victims of crime on a daily basis may respond to victims in ways that seem to minimize their pain and emotional trauma. Because treating victims of crime is routine, hospital staff may fail to explain procedures with sensitivity and care and thereby cause secondary victimization.

Fear of HIV

With the HIV/AIDS epidemic, the trauma of a sexual assault has evolved into a potentially life threatening concern. To date, there have been no documented cases of HIV transmission in adult victims as a result of a sexual assault. This does not mean that transmission is impossible. The physical trauma to the body increases the susceptibility to infection. Child or elderly victims are at increased risk of infection.

Although there is no prescribed way to introduce the topic, a discussion about the rape exam or general health concerns may provide a natural opening to insert the topic. A counselor can also wait for the victim to raise the issue.

A victim's desire to have an offender tested for HIV is understandable, but the results rarely relieve the fear and anxiety. Knowing the results of an offender's present HIV test does *not* guarantee that the victim is free from exposure to HIV. Current research indicates that a person could be exposed to the virus, yet not test positive for months or years. This individual could transmit it to another even though test results are negative. Additionally, in many cases the offender may never be apprehended. Although a number of states have mandated testing of alleged and/or convicted offenders, not all provide for immediate testing or automatic notification to victims.

Due to the high-risk behaviors of numerous sexual offenders, and the frequency with which some children are assaulted by the same offender, the risk of infection for children, when

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compared with adults, is higher. While the risk is higher, the incidence of HIV infection in children is so low that testing is not recommended unless a strong belief or evidence exists that the offender engages in high-risk behaviors or the child exhibits symptoms of sexually transmitted diseases. If testing is deemed advisable, the parent(s) or legal guardian(s) must give permission.

Most people consider sexual assault victims as the victim group at highest risk for HIV infection. However, domestic violence victims should also be considered. Women whose partners use drugs are at risk. Victims may be coerced into using intravenous drugs with shared needles, and consequently exposed to the virus. Most battered women are not powerful enough to convince their partners to use a condom. Sexual assault may be part of the battering cycle.

Cross Cultural Issues in Crisis*

I. Understanding Cultural Contexts

A. CULTURE (cul' tur): "the totality of socially transmitted behavior patterns, arts, beliefs, institutions, and all other products of human work and thought characteristic of a community or population." *The American Heritage Dictionary of the English Language*

1. Issues that help define culture identity include attitudes towards spirituality, birth, dress and other factors.

2. Sources of cultural identity include not only race, ethnicity, nationality and religion but also such attributes as age, gender, language, sexual orientation.

B. Placing yourself in your own cultural context. It is important to know your own values and cultural references before trying to interact with others with different values and references.

II. Issues Of Cultural Perspective

A. Culture and crisis

1. Most literature on trauma and appropriate intervention strategies is based on theoretical and philosophical paradigms drawn from a white,

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Anglo-Saxon, Judeo-Christian perspective in the United States. Yet it is clear that people with different cultural backgrounds, including those backgrounds that are drawn outside of race, ethnicity, nationality or religion, may perceive trauma and appropriate treatment differently.

"All ethnically focused clinical, sociological, anthropological, and experimental studies converge to one central conclusion regarding ethnic America: Ethnic identification is an irreducible entity, central to how persons organize experience, and to an understanding of the unique 'cultural prism' they use in perception and evaluation of reality. Ethnicity is thus central to how the patient or client seeks assistance (help-seeking behavior), what he or she defines as a 'problem', what he or she understands as the causes of psychological difficulties, and the unique, subjective experience of traumatic stress symptoms.

"Ethnicity also shapes how the client views his or her symptoms, and the degree of hopefulness or pessimism towards recovery. Ethnic identification, additionally, determines the patient's attitudes toward his or her pain, expectations of the treatment, and what the client perceives as the best method of addressing the presenting difficulties." E.R. Parsons, "Ethnicity and Traumatic Stress: The Intersecting Point in Psychotherapy," in *Trauma and Its Wake*, ed. Charles R. Figley, Brunner/Mazel: New York, 1985.

2. Several different conceptual schemes provide some insight into how different cultures may need different types of intervention or strategies for service delivery.

   a. The *Axis of Control* describes the degree to which individuals feel in personal control of their lives, and the degree to which they may feel personal responsibility for what happens to them, or their community.

   b. The *Axis of Conflict* describes how people tend to react to conflict in their lives and the goals they seek in resolving that conflict.

   c. The *Axis of Life* attempts to illustrate different perspectives on life and death issues and whether individuals seek to resolve their concerns about life and death through communing with nature, God or technology.

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3. Each perspective described through these suggests differences in attitudes, philosophies and values when providing outreach and service to different cultural groups.

B. Cultural assessment

1. That analysis can be based on any dominant and uniting characteristic of a population. For instance, if a crisis response effort was being planned for an intervention at Gallaudet University, the only four-year liberal arts university for deaf people in the United States, it would be important to think of the frame of reference of the hearing impaired or deaf populations. It would be critical to think about the integration into the hearing impaired culture, or lack thereof, of any particular group or individual within the college.

2. For purposes of illustration on how an assessment might be made, the following is a "checklist" for helping counselors determine the level of ethnic identification that a victim may have.

   a. Determine the extent that the ethnic language is spoken in the home.

   b. Determine how well English (or the dominant language or dialect in a country) is spoken.

   c. Determine the stresses of migration on the ethnic group as a whole and how long the individual or community has been in the United States.

   d. Determine the community of residence and the opportunities the individual has for linking with people of a similar ethnic origin.

   e. Determine the educational attainment and socio-economic status of the individual and the community.

   f. Determine the degree of religious faith of the individual or the community and whether that faith reflects the religion of the ethnic group.

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g. Determine the presence of intermarriage in the community, by the individual, within the individual's family, or within the community as a whole.

C. Understanding Cultural Competence

1. A long-held theory of cross-cultural assistance has been that it is best if members of the same cultural, racial or ethnic group assist each other. That is, an Hispanic/Latino victim theoretically would best be served by an Hispanic/Latino counselor. While this is still a useful goal in some cases, it has not been practical in application since there has often been a shortage of helpers from different cultures in the communities where they are needed most.

2. James Green offers the following definitions of ethnic competence that could be utilized as well to explain a more generic definition of cultural competence. (Source: James Green, *Cultural Awareness in the Human Services.* Prentice Hall, 1982.)

a. "Ethnic competence as awareness of one's own cultural limitations. One of the implications of the model of help-seeking behavior is that the more similar the cognitive and affective characteristics of the client and the worker, the greater chances for effective communication...cultures are in fact different."

b. "Ethnic competence as openness to cultural differences. The belief that underneath we are all the same and that we all share a basic understanding of what is good and valuable in life might well be added to our list of common American values. These beliefs derive from the melting pot ideology, with its assumption (and hope!) that the cultural differences that separate people are less important than the things that unite them, and that manifestations of differences are best under-emphasized in order to assure tranquillity in social relation... The acceptance of ethnic differences in an open genuine manner, without condescension and without patronizing gestures is critical for the development of an ethnically competent professional style..." (While Mr. Green accurately refers to the traditional belief about a melting pot society -- more and more people currently subscribe to the "tossed salad" description of the

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mixture of ethnicities.)

c. "Ethnic competence as a client-oriented systematic learning style. All cross-cultural encounters are potential learning experiences. They may result in the discovery of new information or an enhanced understanding of something not fully appreciated before. Systematic learning depends on whether the worker-as-health-provider is willing to adopt the role of worker-as-learner."

d. "Ethnic competence as utilizing cultural resources. To do so, the worker must know the resources available to the client and how they may best be used. "Resources" here mean not only community agencies but also institutions, individuals and customs indigenous to the client's own community."

e. "Ethnic competence as acknowledging cultural integrity. In catch phrases such as "culture of poverty," "cultural deprivation" or "the black problem" the prejudicial view is expressed. Yet all cultural traditions and extant communities are by definition rich, complex and varied."

III. Recommendations For Cross-Cultural Service Delivery

A. Preparation for providing cross-cultural victim assistance

1. Take advantage of as many cross-cultural educational opportunities as possible.

2. Consider the following possibility. Most people who think of themselves as members of a dominant cultural group spend less time learning about minority groups than do minority groups within the same population. Minorities need to learn about dominant cultural values in order to survive or succeed.

3. Be aware of institutional and latent cultural bigotry. Such bigotry includes racism, sexism, ageism, homophobia, and so forth. While it is easy to identify obvious indicators of bigotry, subtle signs of discrimination, ignorance and prejudice may be more difficult to observe.

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a. Language often carries inherent messages of prejudice.

b. Stereotypes also often are indicators of bigotry.

c. Educational programs can carry implicit biases in favor of the dominant culture.

d. Symbols, traditions, and behaviors may be implicitly discriminatory.

e. It is wise for crisis responders to spend time thinking about the difference between bigoted words, phrases, or humor, and what constitutes non-bigoted or discriminatory speech.

f. Racism is one of the most important factors in cultural experiences. Some have suggested that the more people of one race are exposed to people of other races the less likely either race will be racist. However, others suggest that if people lack any exposure to a different race they may also be non-racist. People become racist when exposed to *negative* experiences or stereotypes about other races. When those experiences or stereotypes are reinforced by media, friends and family, language or formal education, racism becomes entrenched.

B. The following action plan for working in a cross-cultural context is based on further work of Erwin Parsons.

1. Prior to doing cross-cultural intervention, find out about a culture's routines, traditions and impact of family relationships. Routines such as regular mealtimes or mode of dress can affect when and how interventions are made. Crisis responders should be prepared to participate in traditions to the extent possible.

2. The orientation: Have an open discussion about difficulties of working with individuals or groups who come from a different cultural context than yours.

a. Express a willingness to learn about the ethnic group involved.

b. Communicate some appreciation and respect for the individual's culture.

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c. Acknowledge your differences and your limitations.

3. Address practical problems first.

   a. Deal with immediate environmental problems such as financial loss, secure shelter, family conflict and the like that the individual is having difficulty handling by himself.

   b. Build trust.

   c. Assist the survivors or victims with financial resources or compensation if possible.

   d. Help the survivors focus on something tangible that they can accomplish over the next few days.

4. Crisis intervention with cultural focus.

   a. Search for the meaning of suffering and pain relevant to the dominant cultural group involved.

   b. Search for the meaning of death in the culture.

   c. Search for the meaning of life.

   d. Make an effort to acknowledge your limitations with language or other communication concerns, and ask the survivors to tell you if you say something wrong or do something offensive.

   e. Ask survivors to tell their story and talk to them about the crisis reaction.

   f. Ask survivors if their families should be present during discussions or if they would like to have clergy members present.

   g. Ask survivors if they would like to go to a place or worship or if there are any ceremonies or rituals that are particularly directed at crisis in the culture.

   h. Ask survivors to describe what they would like you to do to be of assistance to them and then tell them truthfully what you can

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or can't do.

I. Useful cross-cultural intervention includes: reduction of isolation, relaxation techniques, meditation, education about crisis and trauma reactions, neuro-lingual programming, reframing the crisis in culturally relevant terms, helping individuals to develop control, increase self-esteem and self-regulation.

j. Be aware of culturally specific communication techniques such as the use of eye contact, the integration of food and drink in discussion, the pace of conversation, body language and so forth.

IV. Different Ethnic-Cultural Contexts

Crime victimization is often more prevalent within minority populations than between the dominant population group and minorities; therefore, crime victimization is included as a context for understanding cultural environments. While ethnic groups suffer victimization, they often also become victims of the system when accused of crimes.

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Victims Who Are Disabled

Individuals with a physical disability are more likely to be unemployed, under-employed and less well educated. Women who are disabled are less likely to be married than men who are disabled. People of color who are disabled are more likely to be negatively impacted both economically and socially. Persons with disabilities are not only misunderstood by society as a whole but often by their families as well. They are frequently discouraged from expressing themselves sexually. When working with an individual who has a disability:

- Ask how to best handle any situation of which you are unsure.
- Remember that the victim is a person who happens to be disabled, rather than a disabled person who happens to be a victim.
- An attendant or family member may not be able to communicate with the victim any better then you.
- It is not appropriate to talk to family members without the permission of the victim or instead of the victim.
- The victim should decide if another individual should be present for the interview.
- A care-taker may be the one abusing the victim.
- A victim who at some point lived in an institution or residential facility may have rigid ways of thinking, been encouraged to be friendly to everyone or experienced abuse by staff or other residents.
- An inability to speak does not equal an inability to hear.
- If an interpreter is needed, always speak to the victim, not the interpreter.
- Learn the shorthand, such as “GA” for go ahead, and the protocol for telephone relay services.

When working with a victim who is blind or sight impaired:

- Allow the victim to take your arm when walking rather than taking his/her arm.
- If there is a guide dog, do not comment about the dog’s inability to protect the victim. Asking about a dog’s behavior is a form of victim blaming.
- Introduce yourself every time you enter the room; announce when you are leaving.

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POST-TRAUMATIC STRESS DISORDER, RAPE TRAUMA SYNDROME AND BATTERING

Powerlessness is a political condition, while passivity is a strategy adopted by the powerless to survive...The process of victimization consists of (1) first putting the victim in a position of powerlessness relative to the victimizer, and then (2) repeatedly impressing the victim with his or her powerlessness, including the powerlessness to escape, until the victim adopts passive and compliant behavior to stay alive.

Anne Jones

Post Traumatic Stress Disorder, Rape Trauma Syndrome and Battering

Trauma and Post Traumatic Stress Disorder

In her book, *Trauma and Recovery*, Judith Herman (1992) reminds us that the ordinary response to the horrors that occur in our lives is to expel them from our consciousness. There are certain violations that are unspeakable. While they are unspeakable, they refuse to be buried because there is an equal but opposite conviction that denial does not work. Herman tells us "remembering and telling the truth about terrible events are prerequisites both for the restoration of the social order and for the healing of individual victims." However, since atrocities are frequently shrouded in secrecy, evidence of a traumatic event initially appears as a symptom, not a story.

The distress symptoms of traumatized people concurrently call attention to the existence of an unspeakable secret while deflecting attention from it. We see this clearly in the way people who experienced a trauma alternate between feeling numb and reliving the event. Mental health professionals call this dissociation.

"People who have endured horrible events suffer predictable psychological harm. There is a spectrum of traumatic disorders, ranging from the effects of a single overwhelming event to the more complicated effects of prolonged and repeated abuse. Established diagnostic concepts, especially the severe personality disorders commonly diagnosed in women, have generally failed to recognize the impact of victimization" (Herman, 1992, p. 3).

Traumatic syndromes as well as the recovery processes have basic features. The primary stages of recovery are:

- establishing safety
- reconstructing the trauma story
- restoring the connection between survivors and their communities

The challenge is to help survivors reconnect the pieces, rebuild history and make meaning of their current symptoms in the light of prior events. The traditional sphere in which this occurs for women is within the experiences of domestic and sexual life; while for men it is within the experiences of war and political life.

Studying psychological trauma means coming face to face with human vulnerability to natural acts or disasters and the evil deeds of humans. We witness horrible events. When the events are natural disasters, witnesses are readily inclined to sympathize with the victim. Conversely, when the traumatic events are of human creation, witnesses are caught in the struggle between victim and perpetrator. Morally, it is impossible to remain impartial. Witnesses take sides. The side that many choose is the side of the perpetrator because all that the perpetrator asks is for witnesses or society to do nothing. To side with a victim,

requires the witnesses to share the burden of the victim's pain.

Ask Vietnam veterans if people want to know what really happened during the war, and they will say "no." Society, without individuals or groups willing to hear and report the pain, prefers to look the other way. It happens even more frequently when the victim is already devalued by society (a woman, a child). Devalued individuals find that the most traumatic events of their lives take place outside the range of socially validated reality. Their experiences are unspeakable.

In the field of psychological trauma, there has been debate about whether individuals with post-traumatic conditions should be treated with care or contempt. Are they genuinely suffering or are their stories products of their imagination? Despite the literature documenting the occurrence of psychological trauma, debate still centers on the basic question of whether these incidents are credible and real. Those who spend too much time treating victims of traumatic events are viewed with suspicion by many of their colleagues.

There have been three periods during the past century when a particular form of psychological trauma has become a public concern. Each time, the study of trauma has flourished in association with a political movement. The first of these was hysteria, the archetypal psychological disorder of women. Its study grew out of a political movement of the late nineteenth century in France. The second was shell shock. Its study began in England and the United States after World War I and reached its peak after the Vietnam War. The political setting was the disillusionment with the Vietnam war and the growth of an antiwar movement. The last and most recent traumas to come to public awareness are sexual and domestic violence. The feminist movement brought them to public view. Today's understanding of psychological trauma is built upon a synthesis of these three areas of inquiry.

Not until the women's liberation movement of the 1970's was it recognized that women in civilian life had post-traumatic disorders. The real but private conditions of women's lives were hidden. The privacy created powerful obstacles to consciousness and made women's reality practically invisible. Those who spoke about sexual or domestic abuses were subject to public humiliation, ridicule and disbelief. Women remained silent out of fear and shame, and silence permitted sexual and domestic exploitation.

This confirmed what Freud had dismissed as fantasies. Sexual assaults against women and children were pervasive. A survey conducted in the early 1980's by Dianna E. H. Russell, a sociologist and human rights activist, concluded one woman in four had been raped and one woman in three had been sexually abused in childhood.

For the first time, women designated rape as an atrocity. Feminists redefined rape as a crime of violence - of power and control - rather than a sexual act. Feminists also redefined

rape as a method of political control, forcing the subordination of women through terror.

In 1980, psychological trauma became a "real" diagnosis for the first time. In that year the American Psychiatric Association included in its official manual of mental disorders a new category called Post Traumatic Stress Disorder (PTSD). PTSD occurs in war and peace, as the result of natural disasters or planned attacks, in single or repeated episodes and at the hands of strangers and loved ones.

Diagnostic Criteria for Post Traumatic Stress Disorder*

A. The person has been exposed to a traumatic event in which both of the following were present:

   1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

   2. The person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:

   1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

   2. Recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

   3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

   4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma

2. Efforts to avoid activities, places, or people that arouse recollections of the trauma

3. Inability to recall an important aspect of the trauma

4. Markedly diminished interest or participation in significant activities

5. Feeling of detachment or estrangement from others

6. Restricted range of affect (e.g., unable to have loving feelings)

7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. Difficulty falling or staying asleep

2. Irritability or outbursts of anger

3. Difficulty concentrating

4. Hyper-vigilance

5. Exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social,

occupational, or other important areas of functioning.

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more
With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

* from *Desk Reference to the Diagnostic Criteria from DSM-IV*, American Psychiatric Association

At the moment, the study of psychological trauma seems to be firmly established as a legitimate field of inquiry. Twenty years ago, the literature consisted of a few out-of-print volumes. Now there are new books, new research findings and new discussions every month.

Traumatic events are extraordinary, not because they are rare, but rather because they overpower normal human adaptations to life. Unlike ordinary misfortunes, traumatic events generally involve threats or perceived threats to life. Victims encounter feelings of helplessness and terror.

Long after danger is over, victims experience the event as though it were continually recurring in the present. They are unable to return to "normal," for the trauma repeatedly intrudes. It is as if time stops at the moment of trauma. The traumatic moment breaks into consciousness in the form of flashbacks and nightmares. Small, seemingly insignificant reminders can trigger these memories, which return with the vividness and emotional force of the original event. As a result even normally safe encounters may feel dangerous.

Traumatized people who cannot spontaneously dissociate may attempt to produce similar numbing effects by using alcohol or narcotics. It has become clear that traumatized people run a high risk of compounding their difficulties by developing dependence on alcohol or other drugs.

Although dissociation, or even intoxication, may be adaptive defense mechanisms at the moment of total helplessness, they cease to be once the danger is past. They prevent the integration necessary for healing. Unfortunately, dissociation, like other symptoms of the post-traumatic stress syndrome, is persistent.

Traumatic events place enormous stress on basic human relationships. They can sever ties of family, friendship, love and community. They can shatter the self image that is formed and sustained in relation to others. They can undermine belief systems. They can violate the victim's faith in a natural or divine order and cast the victim into a state of crisis. Traumatic events destroy victims' fundamental assumptions about the safety of the world, the positive value of the self and the meaningful order of creation.

Post Traumatic Stress Disorder, Rape Trauma Syndrome and Battering

The damage to relational life is not a secondary effect of trauma. Traumatic events destroy victims fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation.

Support from other people may temper the impact of the event, while blame or a hostile response may compound the damage and intensify the traumatic syndrome. After traumatic life events, survivors are highly vulnerable. Their sense of self is shattered. That sense can be rebuilt only as it was built initially, in connection with others.

Sharing the traumatic experience with others is an element of recovery. In this process, the survivors seek assistance not only from those closest to them but also from their communities. The response of these communities has a powerful influence on the ultimate resolution of the trauma. Re-establishing the bonds between the traumatized person and their communities depends upon public acknowledgment of the traumatic event and some form of community action. Once communities acknowledge that a person has been harmed, they must assign responsibility for the harm and repair the injury. These two responses - recognition and restitution - are necessary to rebuild the survivor's sense of order and justice.

Rape-Related Post-Traumatic Stress

- Nearly one-third of all rape victims develop Rape-related Post-traumatic Stress Disorder (RR-PTSD) sometime in their lifetimes, and more than 11 percent suffer from RR-PTSD at the present time.

- Thirteen percent of American women surveyed had been raped and 31 percent of these rape victims developed Rape-Related-PTSD.

- Of the 683,000 women raped each year in this country, approximately 211,000 will develop RR-PTSD each year.

- Rape victims are three times more likely than non-victims of crime to have a major depressive episode.

- Rape victims are 4.1 times more likely than non-crime victims to contemplate suicide. Thirteen percent of all rape victims actually attempt suicide.

- Compared to non-victims of crime, rape victims are: 13.4 times more likely to have two or more major alcohol problems; and 26 times more likely to have two or more major serious drug abuse problems.

Post Traumatic Stress Disorder, Rape Trauma Syndrome and Battering

from *Rape in America: A Report to the Nation*, National Victims Center, 1992.

Rape Trauma

An acute and long-term emotional reorganization process that occurs as a result of completed or attempted rape, and lasts for months or years after the actual rape has occurred.

Stages

A. Acute/Impact Reaction

1. Immediately and several days after the rape
2. Ways of showing anger
   a. Expressed style - fear, crying, smiling, restlessness, tenseness
   b. Controlled style - feelings hidden by calm, composed attitude
3. Somatic Reactions
   a. Physical: soreness and bruising from the physical attack, irritation and throat infections for women forced into oral sex
   b. Skeletal muscle tension: inability to sleep or restlessness while asleep, edgy and jumpy over minor incidents
   c. Gastrointestinal Irritability: stomach pains, appetite affected, nausea
   d. Genital Disturbances: vaginal discharge, an itchy, burning sensation on urination, chronic vaginal infections, rectal bleeding/pain
4. Emotional Reactions
   a. Fear of: how friends will react, not being believed, rapist retaliation
   b. Shock/disbelief

c. Agitation/anger

d. Shame/self-blame

e. Confusion/bewilderment

f. **Extreme** sense of guilt

5. Her needs

a. Someone to believe her

b. Emotional support/acceptance

c. Reassurance about how she handled the attack

6. Additional needs

a. Examination by physician even if it is several days after the attack

b. Aid in reporting the crime

B. Outward Adjustment Phase

1. Lasts from weeks to months

2. Emotional reactions

a. Intense fear: pregnancy, V.D., physical violence or death, crowds, being approached from behind, intercourse, fear of the unexpected (because the rape may have been unexpected)

b. Anxiety: anticipating medical exams, court hearing in which she'll face the rapist, prospect of losing partner

c. Denial - refusing to believe the rape happened

d. Lost sense of security

1. Nightmares in which

a. Victim is in danger and wants to do something but wakes before acting

b. Victim succeeds in fighting off assailant

c. Humiliation, embarrassment

d. Self-blame

e. Feelings of wanting revenge

f. Fear of sexual things

g. All problems become intensified

3. Physical signs

a. Antipregnancy medicine - causes nausea. Consist of 25-50 mg. of diethylstilbestrol (DES) administered per day for five days

b. Anti-venereal disease medicine - causes nausea. Consists of 4.8 million units of aqueous procaine penicillin administered intramuscularly

c. Burning sensation when urinating and itching or burning discharge from vagina

d. Tension headaches

4. Her needs

a. Counselor to be patient as she retells her story; time and time again, if necessary

b. Aid in approaching family and friends

c. Counseling with partner about her fear of sexual intercourse

d. Meet with other rape victims so she won't feel as isolated and helpless

C. Depression Phase

Post Traumatic Stress Disorder, Rape Trauma Syndrome and Battering

1. Lasts days to months
2. Her emotions
    a. Loss of self-esteem as her defenses break down
    b. Obsessive memories
    c. Uncertain about being able to control her life and environment
3. Her needs
    a. Support through the sentencing of her rapist and any possible end to intimate relationship
    b. Overcome her guilt feelings
    c. Help in re-establishing intimate relationships

D. Integration and Resolution Phase

1. Lasts months to years
2. Her emotions
    a. Lack of trust in men
    b. Anxious and depressed when something reminds her of the rape
3. Her needs
    a. Support and someone to listen
    b. Guidance in steps to make her feel more safe
        1. Obtain unlisted phone number
        2. Move to another location
        3. Extended vacation to get away for a awhile

Post Traumatic Stress Disorder, Rape Trauma Syndrome and Battering

Reactions Above and Beyond Rape-Related PTSD That May Require Different Kinds of Intervention

- Depressed for an extended period of time (several weeks)
- Demonstrated psychotic behaviors
- Talk of or attempts at suicide
- Use of alcohol or drugs to self medicate
- Abrupt/dramatic changes in sexual behavior; confusion about sexuality
- Expresses a hatred of sex

Post Traumatic Stress Disorder, Rape Trauma Syndrome and Battering

Ten Warning Signs of Mental Illness*

1. Marked personality change.
2. Inability to cope with problems and daily activities.
3. Strange or grandiose ideas.
4. Excessive anxieties.
5. Prolonged depression and apathy.
6. Marked changes in eating or sleeping patterns.
7. Thinking or talking about suicide.
8. Extreme highs and lows.
9. Abuse of alcohol or drugs.
10. Excessive anger, hostility or violent behavior.

* from the American Psychiatric Association

A person displaying one or more of these warning signs may have a mental illness and should be evaluated by a mental health professional as soon as possible. If the individual has experienced trauma due to crime or abuse, the behavior may be a normal response to an abnormal event.

Depression

The most common complaints that patients tell their physicians are the common symptoms of depression. In 1990, the American Psychological Association reported that depression annually afflicts about 7 million American women and is responsible for 30,000 suicides. This is twice the rate of depression found in American men. The rate of depression and victimization in women may be linked.

Symptoms

- unusual weight gain or loss of weight
- either sleeping too much or insomnia
- inability to enjoy pursuits which formerly gave pleasure
- brooding over the past
- pessimism about the future
- loss of interest in sex
- extreme irritability
- overreaction to trivial events
- trouble with concentration or memory
- neglect of appearance
- frequent thoughts of death or dying
- social isolation
- low self esteem
- feelings of helplessness

A common feature of depression includes the tendency to over generalize the meaning of events. Instead of dealing with adversities as isolated incidents, people with depression see incidents as part of a larger pattern. They are inclined to see things as black or white. For example, a mother trying to solve family problems, realizes that some solutions will work well while others will not. But the mother who is depressed tends to feel there are no solutions.

Recovery

Depression can often be successfully treated. Depression can be caused by sudden changes in brain chemistry (endogenous) or by personal tragedy or trauma (exogenous) which trigger chemical changes. Serotonin and norepinephrine are chemicals that affect mood. When confronted with trauma or tragedy, a person may become depressed. The amounts of serotonin and norepinephrine in the brain plummet. After about three weeks,

the levels of the chemicals usually rise and the person begins to feel better. For some people, the levels of serotonin and norepinephrine do not return to normal. With low levels of the chemicals, the person may feel continually "blue." But if the quantity drops further, it could lead to clinical depression.

There are drugs which can restore the levels of serotonin and norepinephrine. In the last few years several drugs have been approved by the FDA for the treatment of depression that have fewer side effects and begin to work more rapidly.

For people who suffer from depression as a result of a traumatic event, medication may help them to focus and process what has happened. It can help them sleep, increase their energy levels, and reduce feelings of hopelessness. In addition to medications, talk therapy and support groups are used to treat depression. Frequently they are used in combination.

Hostage in the Home*

*Written by Jeri Martinez; exceprt used with permission

Post Traumatic Stress Disorder, Rape Trauma Syndrome and Battering

Domestic Violence Seen Through Its Parallel, The Stockholm Syndrome

When most people hear the term domestic violence, they think of punches, bloody noses, black eyes, broken ribs. So people invariably react by saying, "***I*** wouldn't take that! The **very first time** he hit me, I'd be out the door!" Thinking that one becomes an abuse victim at the moment of the first assault, they imagine how they would react to an assault by a stranger and blame the abuse victim for not reacting to her[1] partner's assault as they think they would.

People who work with abuse victims are often frustrated and angered by decisions victims make which they consider bizarre and inexplicable. For example, abuse victims often:

- minimize their injuries
- refuse to participate in the prosecution of their assailants
- put up bail to get their abusers out of jail
- stay with or return to the men who abuse them

Because physical abuse is concrete and is all that outsiders can see, and because people do not think that just physical assaults would make someone do the "crazy" things abuse victims do, they conclude that the victim is mentally unbalanced.

In fact, the victim's mental state *is* altered as a result of her relationship with the abuser. Her perceptions of herself, her abuser and life in general *have* been altered. Not solely due to the physical abuse she may have suffered, but due to years of *psychological assaults*, the unremitting use of tactics defined by Amnesty International (1973) as "psychological torture." The abuse victim's very different view of her situation is the result of a lengthy process.

[1] Although it is clear that there are men abused by female and male partners, and there are women abused by female partners, because "[a]nalyses of police and court records in North America and Europe have persistently indicated that women constitute 90-95% of the victims of those assaults in the home reported to the criminal justice system," (Dobash, et al., 1992), herein the victim will be referred to as female and the perpetrator as male. The bottom line is that ***pain has no gender***, and, as this analysis shows, human beings exposed to psychological torture will react similarly, *regardless of sex*. Therefore, the author asks readers to mentally translate the term "battered women" into "battered women or men."

The abuse victim being subjected to her first assault is a very different person from those who judge her. Prior to that first assault, the abuser has spent *months or years* using escalating tactics of mental abuse and intimidation, using "minor" physical aggression to control her before moving to actual physical assault. He undermines her psychologically

before he ever lays a hand on her. *By the first time the abuser strikes her, the victim is **no longer** like unvictimized people, and simply cannot react like them. Living in fear while undergoing constant psychological degradation each and every day changes her far beyond what outsiders can imagine.*

One way to make the complex process of victimization that abusers use to gain and maintain control over victims understandable to the average person, is to look at domestic violence through its parallel: the Stockholm Syndrome.

The Stockholm or Hostage Syndrome is a "conversion" that occurs when an individual is terrorized while being held in captivity. Given certain specific circumstances, a hostage's view of his/her captor and his/her relationship to him changes 180 degrees from hatred to adulation.

The best way to illustrate this psychological turn-around is through the 1985 terrorist takeover of Flight 847 in Europe. (Walker, 1989) After capturing the plane, the terrorist released the women and children - presumably to show what good guys they were. Left on the plane were two sailors and a group of wealthy American businessmen.

The terrorists took the plane to the Beirut airport and held the men captive on the tarmac for ten days. During the ten days of captivity, the hostages had guns held to their heads and put in their mouths, and had their lives threatened. They watched their captors beat one of the sailors to death and dump his body out of the tail section of the plane. Most people remember this hijacking from that detail because the image was so vivid in the newspapers and on TV.

During their captivity, one of the hostages was forced to read a political statement to the media from the cockpit of the plane. After their rescue, the hostages were flown to the U.S. When they got off the plane, waiting reporters rushed over to interview the man who had read the statement earlier in the week. They asked him only three questions:

- "Is it good to be home?" *"Yes, it's wonderful."*
- "What was it like?" *"It was hell."*
- "What were the kidnappers like?" *"It's funny you asked that. They weren't bad people. **They let me eat, they let me sleep, they gave me my life."***

Then he said something advocates and police officers have heard from hundreds of victims of abuse: "*They have such potential to be good people*."

He went on to talk about how the terrorists had to do what they did to get publicity for their

cause and how America mistreats third world countries. Within minutes, a government spokesperson appeared on camera to say that the kidnappers were not really "good people" - that the man who had been interviewed was a victim of the Stockholm Syndrome. (Walker, 1989)

The Stockholm Syndrome was named for the terrorist take-over of a bank in Stockholm, Sweden, in August 1973 when three women and one man were held hostage for six days by two men. (Cooper, 1978) During that incident, when the police stormed the bank to rescue the hostages, the captives fought police at the side of the captors. Afterwards they blamed the police for endangering them, and one of the freed hostages became engaged to a jailed terrorist. This last occurrence led to the investigation and definition of the Stockholm Syndrome.

Since then, following numerous hostage-takings, the world has seen former hostages:

- minimize their injuries
- refuse to participate in prosecuting terrorists
- visit their captors in jail
- recommend and pay for defense counsel

... ALL THE SAME THINGS BATTERED WOMEN DO.

While hostages sometimes refuse to prosecute terrorists, hostages receive compassion and understanding. But all too often, when a battered woman is afraid to prosecute her batterer -- who, unlike terrorists, is out on the street knowing where the victim and her loved ones live -- her "refusal" to prosecute is used as an excuse by some members of the criminal justice system to refuse to protect her and prosecute him.

The bond of interdependence between captive and captor called the Stockholm Syndrome develops "when someone threatens your life, deliberates, and doesn't kill you." (Symonds, 1980) The relief arising from the removal of the threat of death generates intense feelings of gratitude as well as fear, which combine to make captives reluctant to display negative feelings toward the terrorist. This is *pathological transference*, a kind of "conversion." Recognition that the terrorist/abuser has the power of life and death over them, combined with gratitude that he has let them live, causes a unique change in perspective -- the hostage/abuse victim and children come to see the captor/abuser as a "good guy," even a savior. "The victim's need to survive is stronger than his impulse to hate the person who has created his dilemma." (Strentz, 1980)

Overwhelmingly grateful to terrorists for giving them life, hostages focus on their perceptions of their captors' kindness, not their brutality. Similarly, battered women convince themselves that the abuser is a good man whose violence stems from problems

they can help him solve.

Stockholm Syndrome develops when an individual is subjected to four conditions (Graham, et al., 1988)

Condition One

A person is held captive and cannot escape, so her or his life depends on the captor. The reality of captivity is easy to understand in the context of hostages or prisoners because the walls which confine them are made of brick or stone or wood. However, the walls which confine the abuse victim are built from societal attitudes and practical barriers, as well as the psychological pressures she is subjected to every day by her abuser.

A now-familiar example of isolation while living in the public eye is Nicole Brown Simpson. That the beautiful, wealthy wife of a famous public figure could actually be a victim of domestic violence -- the cliché being a low-income, downtrodden hag -- electrified America and blasted open the stereotypical image of battered women. Because her image and circumstances are now firmly engraved in the public consciousness, it is easier to evoke thoughts of captivity in the midst of everyday "freedom."

Societal Barriers - Many victims ask family, friends, police and/or the courts for protection or help to escape, only to be refused and find that nothing stopped the abuser from punishing them for the attempt. Often it is not only the abuser, but his family and friends, who threaten, harass, intimidate and harm the victim seeking help. Victims all too frequently learn that no one will treat their situation seriously, and they feel as though they have run into a brick wall when they hear:

- "What did you do to deserve it?"
- "Give him another chance. Stand by your man."
- "You made a vow before God to stay with him 'in sickness and in health until death do you part."
- "Clearly he's sick, so it's your duty to stay with him and help him."
- "It's only a family argument -- I'm not going to arrest him."
- "We're releasing him on his own recognizance."
- "We don't prosecute first-time batterers -- we send them to diversion."

These responses to her appeals for help, repeated over and over, teach the victim that she cannot escape. Her situation is very similar to that of a dog being trained to stay within a certain area through the use of a shock collar. Every time the dog reaches the edge of the designated area, the collar shocks it. Eventually, after enough shocks, in the animal's mind

there is an invisible wall around the property. After that training, when the electricity is turned off, the dog will still not go beyond the border. Invisible to the outside observer, the wall of pain and fear is very real to the animal.

Financial Barriers - Another brick in the wall preventing victims from escape is lack of access to money. Abusers control the family finances to more effectively control victims because their financial dependence gives him power. If the victim has a job, the abuser's harassment may cause her to lose it. "Battering, not pregnancy, is the main reason women leave the workforce altogether." (Jones, 1991) Lack of access to money makes it extremely difficult, if not impossible, for even a middle-class woman to be able to afford to take care of herself and the children if she leaves.

Even in the 1990's, a woman faces major barriers when seeking a way to support herself and her children if she leaves her abuser:

- According to the U.S. Bureau of Labor Statistics, women *still earn only 66¢ for every dollar in annual salary an American man earns* - even female college graduates. (Faludi, 1991)

- More than 80% of full-time working women earn less than $20,000 a year -- nearly double the male rate. (Newton, 1989)

One of the prevalent myths about divorce is that women receive generous alimony and child support from former husbands. While this may be true for some, it is far from true for the majority:

- In the first year after a divorce, the women and children suffer a 33% drop in their standard of living, while the man enjoys a 10% to 15% rise in his. (Duncan & Hoffman, 1988)

- One year after going to court and being awarded support, 88% of women with full restraining orders and 81% of those without had not received any money to support themselves, and 64% of those with orders and 49% of those without full orders had never received any child support from the abuser. (National Center on Women and Family Law, 1993)

- "Divorced men are now more likely to meet their car payments than their child support obligations -- even though, as one study in the early '80s [sic] found, for 2/3 of them, the amount owed their children is *less* than their monthly auto loan bill." (Hewlett, 1986)

Post Traumatic Stress Disorder, Rape Trauma Syndrome and Battering

Children - When the couple has children, the situation becomes extraordinarily complicated. The children, who dare not confront their father, often blame their mother for not pleasing him and avoiding the violence that terrifies them: "Why did you do that, Mom? You *knew* it would make him mad." Having no safe release for their fear, they may take the side of the parent they perceive to be the stronger, wanting to be on his side to escape his violence themselves.

The mother worries that their lower standard of living after separation or divorce will result in increased danger to her children from a new environment: exposure to drugs, gangs, etc.

Most horrifying of all to the victim is the abuser's most common and most dreadful threat: he will win custody of the children, or simply snatch them.

Chesler (1991) found that:

- Fathers who fought for custody won 70% of the time, ***whether or not they were absentee or violent fathers.***
- 12% of the mothers and 37% of the fathers she studied kidnapped their children.
- ***All*** of the maternal kidnappers were primary caretakers and had been prevented by the fathers from seeing their children.
- 14% of the paternal kidnappers had been involved in primary child care. ***None*** had been prevented by the mothers from seeing their children.
- ***None*** of these fathers was economically, legally or custodially punished.
- Of the smaller number of maternal kidnappers, 80% were both found and punished.

The abuser's threat to gain custody through the legal process can be seen as easily plausible. Since he has spent years denying his violence to his partner, the children, and their families, he is well practiced at denying his abuse. So he behaves precisely in accordance with the criteria judges use in assessing a witness' veracity. He makes good eye contact with the judge, speaks calmly and tells a coherent story. In contrast, the victim, often unrepresented, has also spent years denying the violence. Her testimony may be the very first time she has spoken in public about the degrading abuse to which she has been subjected. So she doesn't make a very good witness. She may avoid eye contact, break down on the witness stand, and omit details.

- More than 40 children are abducted by a parent each hour in this country. Most of these abductions are perpetrated by fathers or people acting on their behalf, including step-mothers and relatives. Fifty-four percent of these abductions are short-term manipulations around custody orders, but 46% involve concealing the whereabouts of the child or taking the child out of state. Fully 82% occur between the couple's

separation and two years after the parents have separated or divorced. (Finkelhor, et al., 1990)

- In 1988, an estimated 163,200 children abducted by parents or family members were taken across state lines, concealed from or prevented from having contact with the custodial parent, or taken with the intention of being kept indefinitely or changing their custody. (Finkelhor, et al., 1990)

- More than 54% of abductions occur in the context of domestic violence. (Greif & Hegar, 1992)

"Each publicized custody battle terrorizes married, divorced, and unwed mothers in non-measurable and unknown ways." (Chesler, 1991)

Scarcity of Available Services - Services for abuse victims are poorly funded by state and federal governments, and thus are not available everywhere, and are generally offered by networks of volunteers.

- Between 1983 and 1987, one-third of the 1 million battered women in the U.S. who sought shelter were turned away due to lack of space. (Women and Housing Task Force, 1988)

- In 1991 there were 3,200 animal shelters in the U.S., but only 1,200 shelters for abuse victims. (Washington Post, 1991)

- "There are no governmental protective services for battered women. Furthermore, over one half of all counties in the U.S. have no battered women's programs." (Jackson, 1990)

If his victim does succeed in escaping, the abuser often resorts to even more serious violence because he has lost the very people his abuse is aimed at keeping and controlling -- his partner and children.

Some men would rather kill "their" women and/or themselves than see women make a new life. We, and victims, see these stories in the press and on television regularly. Victims know full well that their escape may end in their death. Statistics verify that battered women's lives do indeed depend on their batterers.

- Approximately 70% of murdered women are killed by a husband, lover or estranged same. Approximately 2/3 of those murdered by intimate partners or ex-partners have been physically abused before they were killed." (Campbell, et al., 1992)

- The most common type of homicide-suicide episodes, representing fully 50% to 75% of all murder-suicides in the U.S., typically involved a male between the ages of 18 and 60 years who physically abused his girlfriend or wife, feared her infidelity or estrangement, murdered her, and committed suicide, usually by firearm. (Marzuk, et al., 1992)

Condition Two

The captive is isolated from outsiders so that the only other perspective available to her or him is that of the captor.
Hostage-takers routinely keep information about the outside world's response to their kidnapping from captives to keep them totally dependent.

Like terrorists, abusers isolate their victims. Isolation is the back-drop against which the entire drama is played because in isolation, all the victim hears is the negative messages of the abuser. Abuse victims are isolated in many ways:

Geographical Isolation - In rural areas, she may be isolated because she lives at the end of a road or in the back woods. There are few things more terrifying than living with someone violent, knowing that no matter how loudly you scream, no one will hear you. No one will come. No one will call 911 when the batterer rips out your phone.

Social Isolation takes many forms:

Family/Friends/Work - Many batterers control who the victim's friends are and who she spends time with, determining who the couple will socialize with, or whether they will socialize at all. If he is angry, threatening, violent, or is even merely argumentative in front of others, they avoid associating with the couple. Thus the woman is left even more alone so the abuser's demeaning messages become her reality because they are all she hears. Kept totally under his thumb, she cannot bond with anyone else.

Many abusers are obsessively jealous and possessive. They conduct surveillance on their partners, "following [them] around, interrogating the children, eavesdropping on telephone conversations, and making frequent telephone calls to monitor [their] activities... Closely related to this is extreme possessiveness which is often manifested by the abuser's unwillingness to accept the end of the relationship." (Adams, 1990)

"Women ... are subjected to ongoing harassment and pressure tactics including multiple phone calls, homicide or suicide threats, uninvited visits at home or work, and manipulation of children.... Some abusers use their children as emissaries who are responsible for spying on mom's activities or for convincing mom to 'let Daddy come home'." (Adams, 1990)

Post Traumatic Stress Disorder, Rape Trauma Syndrome and Battering

Often when a victim has separated from her abuser, his harassment in the workplace leads to her losing her job.

- Abusive husbands and lovers harass 74% of employed battered women at work, either in person or over the telephone, causing 56% to be late for work at least five times a month; 28% to leave early at least five days a month; 54% to miss at least three full days of work a month; and 20% to lose their jobs. (New York Victim Service Agency, 1987; Schechter & Gray, 1988)

Religion - Most organized religions are based on the premise that suffering on earth is the prerequisite for eternal life in Heaven. Christians are taught, "God never gives you a burden greater than you can bear." They are told to carry the cross of their pain and suffering just as Christ did, that suffering on earth is the price you pay to earn eternal life in Heaven.

Romantic Relationships - The batterer repeatedly tells his victim, "If you leave me, no one will want you." Over time, she comes to believe that and, when considering whether to leave, she has to confront the very real possibility that she will never have another relationship -- and accept that perhaps she will never have sex again. Never again will a man touch her with love and caring.

The Isolation of Stereotypes - Society's stereotypes reinforced by the abuser's psychological brainwashing form a powerfully effective section in the wall of isolation. In an effort to evade a realization of their personal vulnerability to being victimized, the public accepts victim-blaming stereotypes about crime victims in general (Bard & Sangrey, 1986), and abuse victims in particular. One of *the* most widespread stereotypes about battered women is: ***Women are masochists -- they ask for it -- they stay because they like being beaten.*** This myth is repeated as truth by people who know little or nothing about the reality of violent relationships.

Battered women who are still hiding the violence of their home lives hear this "common wisdom" from friends, family, co-workers and the public so often that many become convinced of its truth, and believe that people will look down on them and be unwilling to help them. Taught first by batterers and then by the stereotype that the violence is their fault, shame and fear keep victims silent. So they stay in the relationship, afraid to turn to anyone for help for fear of being rejected and despised.

> "The propensity to fault the character of the victim can be seen even in the case of politically organized mass murder. The aftermath of the Holocaust witnessed a protracted debate regarding the 'passivity' of the Jews and their 'complicity' in their fate. But the historian Lucy Dawidowicz points out that 'complicity' and 'cooperation'

> are terms that apply to situations of free choice. They do not have the same meaning in situations of captivity." (Herman, 1992)

Another common stereotype about battered women is the "Bad Faith" Stereotype. This stereotype is described by members of the justice system as the woman who uses and abuses the abuse prevention process to manipulate and punish her male partner.

The danger of this stereotype is illustrated by the *Thurman vs. Torrington* case. Because the Torrington Police Department saw Tracey Thurman as a stereotype rather than an individual, they were blinded to her real danger -- which led to her being disfigured and partially paralyzed for life -- and to their having to pay her $1.9 million in damages.

While some women, abused and not abused, certainly do "abuse" the system, and while one finds evil among some members of any group, the *generally held stereotypes about battered women are not true of the vast majority of victims*.

Isolation strengthens and enforces abusers' use of the following tactics to demoralize and brainwash their victims because the victim has no one to turn to for a "reality check." The tactics used by abusers have been defined by Amnesty International (1973) as psychological torture. Yet while world opinion can be mobilized and concrete sanctions imposed against countries which treat prisoners and dissidents in this way, even though they use these same tactics against women, abusers are rarely prosecuted or receive meaningful sentences. These tactics are the cornerstone of the brainwashing and manipulation used on P.O.W.'s, political dissidents and hostages as well as battered women:

Verbal Humiliation and Degradation - This is not simply the use of foul language. It is unrelenting criticism and constant attacks on the victim's worth as a human being. Who she is and what she does are never good enough. It is not only the viciousness of these attacks that makes this tactic so effective -- it is the constant repetition of the batterer's denigrating messages. Repeated humiliation is the abuser's strongest weapon. The messages that she is utterly worthless, and the cause of his anger and violence become part of the victim's self-image due to constant repetition of the same theme -- which he delivers verbally and reinforces with his fists.

Self-blame is a common reaction to being victimized. (Bard & Sangrey, 1986) But in addition to natural feelings of self-blame (it is easier to deal with guilt than the fear of reccurrence [Miller & Porter, 1983]), the abuse victim's self-blame is actively stimulated by her abuser, and her suffering minimized:

- "'If we had a problem, it's because I loved her so much... Like all long-term

> relationships, we had a few downs and ups.... All this press talk about a rocky relationship was no more than what every long-term relationship experiences... At times I have felt like a battered husband or boyfriend but I loved her.'" (Simpson, 1994)

Each of us forms our self-image from how others respond to us. The more important a person is to us, the more we value and rely upon their opinion of us. Women in our society are taught to believe that a partner's love is supposed to be the most important thing in their lives. Success, financial gain, status and prestige are supposed to be secondary to finding a partner and keeping his love. So, when the abuser rejects her, the victim has to admit to herself that she has failed in making what society has taught her was the single most important choice in her life, that of a husband or lover. Thus, she has to overcome the socialization of a lifetime as well as her love for her partner, to reject his importance in her life, in order to discount his opinion of her.

Threats of Harm - The abuser threatens to harm the victim, the children, her family, pets, treasured personal belongings; he threatens to abandon her and the children, to further isolate them, to snatch the children or to kill her, the children or himself. These threats often include detailed descriptions of how he will harm or torture her loved ones. In the beginning, the abuser's threats are usually ominously vague, and he may not carry them out.

Gradually, "mere" threats alone become insufficient to maintain control over partner and children, so he begins carrying some of them out. When he does act on his threats of physical violence, studies show that his victim's likelihood of injury is great:

- "Women suffering violent victimizations were almost twice as likely to be injured if the offender was an intimate (59%) compared to offenders who were strangers (27%). Women were also [almost twice] more likely to receive injuries requiring medical care if the attacker was an intimate (27%) compared to a stranger (14%)." (Bachman, 1994)

- "Domestic violence is the largest single cause of injury among women seen at hospital emergency rooms, more common than auto accidents, muggings, and rapes combined." (Stark & Flitcraft, 1985)

- "[A]s many as half of the domestic 'simple assaults' actually involved bodily injury as serious as or more serious than 90% of all rapes, robberies, and aggravated assaults." (Langan & Innes, 1986)

Eventually the victim is constantly off balance -- a key factor in brainwashing -- because she never knows whether or when he will act on his threats.

Post Traumatic Stress Disorder, Rape Trauma Syndrome and Battering

Enforcement of Trivial Demands - This tactic forces the victim to develop the habit of complying with whatever demands the abuser chooses to make. Her life is governed by long lists of demands and rules: how clean the house must be, how the children are to be disciplined or dressed or fed, having to account for how she spends her time, where she goes, whom she sees, etc. Whatever an individual abuser's demands, when they are not met, he demonstrates his power with a variety of physical and psychological punishments. The victim lives in a continual atmosphere of impending doom.

Monopolizing Perceptions - The abuser creates an atmosphere so dangerous that the victim becomes totally focused on remaining safe here and now. Monopolization of perception is the psychological state which results from living in an atmosphere of fear and impending punishment created through the use of the psychological manipulative tactics discussed above by themselves or in combination with physical assaults.

Because the outpouring of the abuser's rage is so unpredictable, the victim protects herself and the children by maintaining the family and the home in accordance with his ever-changing demands. Her time and energy are focused on the abuser and his impending rage over anything that may turn out to be "wrong." She becomes exhausted by her constant efforts to totally control the home environment to pacify him: controlling the children, pets and visitors; attempting to anticipate his whims and assuage his frustrations; and suppressing her fear, sorrow and rage, which, if revealed, will lead to punishment.

Taught that they can be punished for virtually anything they say or do, the victim and children become afraid to make choices, to do anything on their own. For abuse victims and their children, as well as POW's and hostages, all aspects of life relate only to how the batterer/captor will react. They "walk on eggshells," constantly trying to read the captor's mind to anticipate his wishes and thus deflect his anger. Abuse victims become totally absorbed in arranging every aspect of their lives to keep him calm.

Since abusers use precisely the same techniques as terrorists, it is completely logical that battered women suffer the same psychological effects as hostages. Subjected to these tactics on a daily basis, victims also isolate themselves out of shame, believing that they have failed their partners and thus are failing at what society has taught them throughout their lives are the most important roles a woman can assume -- wife, mother and homemaker. Trying to do better, but never succeeding in ending the beatings, they become depressed, apathetic and despairing. Abusers constantly tell them the abuse is their fault, and they hear from their families as well as his, "You've made your bed, now lie in it." Even the children, who dare not confront the abuser, release their tension and fear by blaming their mother for not pleasing him and avoiding the violence that terrifies them.

The tremendous isolation in which the victim lives causes her to derive too much of her

identity and self-esteem from the batterer, so when he rejects her with verbal degradation and beatings, the entire foundation of her self-esteem is demolished. Her learned belief in her personal unworthiness and her blame for the violence makes her isolate herself from family and friends who may also blame her for not keeping the violence in check.

Walled in by outsiders' attitudes, victims come to believe there is nowhere they can turn for support, much less assistance. The victim is forced to take on the abuser's perspective of her because she has found that when she reaches out for a different viewpoint, she is too often rebuffed.

Eventually, the mental cage the abuser has erected around the victim becomes as strong as the walls which confine and isolate the hostage.

Condition Three

The captor threatens to kill the victim and is perceived as having the capability to do so.

Threats of death are a nearly invariable feature of life with an abuser. And the almost universal threat of batterers who kill their victims is the chilling: "If I can't have you, no one will." Because we see this threat so often repeated in media reports about those murders, victims are well aware of the danger represented by such threats -- and abusers recognize the power they can gain by making the same threat. These threats become real when looking at the statistics:

- From 1976 to 1987, of all deaths resulting from one partner killing another (married, common-law, ex-married, dating), 61% of victims were women killed by male partners, and 6% of male victims were killed by female partners. (Browne & Williams, in press, 1992; Bureau of Justice Statistics, 1989)

- **100%** of Vermont's female homicide victims in 1993 are believed by law enforcement authorities to have died at the hands of an intimate partner or family member. (Martinez, 1994)

So the victim decides it is safer to stay and endure an occasional beating than to leave and be murdered -- an entirely reasonable choice. The victim's focus narrows to her and her children's short-term safety rather than long-term security through escape. But at this point, the victim is no longer her husband's or lover's partner -- she is his prisoner.

Condition Four

The threatening person is perceived as showing some degree of kindness to the victim being threatened.

Kindness is the cornerstone of the Stockholm Syndrome. *Stockholm Syndrome will not develop unless the captor exhibits some kindness towards the victim.* If the captor/batterer is purely evil, the victim responds with hatred. But if the captor/batterer shows some kindness, in the midst of terror the victim submerges the hatred s/he feels in response to the terror, and concentrates on his/her captor's good side in order to protect him/herself.

In many abusive relationships, the abuser is contrite and apologetic after an abusive incident. This is called the Honeymoon Stage of the Cycle of Violence. (Walker, 1979) Following a period during which the tension between the couple builds to a violent explosion, the abuser, filled with remorse, promises with genuine sincerity of his repentance. Wanting to believe him, and convinced by his sincerity, the victim convinces herself that it was not really that bad, and that he can change. So the abuser convinces the victim and everyone else (*including himself*) that he can and will stop being violent. He excuses his violence by blaming stress or alcohol or drugs. At the same time he is making excuses to deny full responsibility, he also offers justification to deny wrong-doing -- primarily blaming the victim for provoking him: "If you were a better wife, I wouldn't lose my temper."

Often the psychological confusion and shock of the traumatic incident cause both victim and perpetrator to minimize, deny or suppress the details of the violence. The couple rebounds in warmth and intimacy. It is at this time that the victim is most thoroughly victimized psychologically because his manipulation of her emotions leaves her feeling responsible both for him *and* for her own victimization.

It must be remembered that, like most relationships, when it began, the relationship was probably satisfying. Since no one is 100% bad, or 100% good, even despite the battering, there are aspects of the relationship which remain rewarding, and with many batterers who never go beyond the stage of moderate assaults, the beating may be infrequent.

The bonding between captive and captor called the Stockholm Syndrome "is no longer considered unusual by professionals who negotiate with hostage-takers. In fact, they encourage its development, for it improves the chances of the hostages surviving, despite the fact that it means the officials can no longer count on the cooperation of the hostages in working for their own release or in later prosecuting the hostage-takers." (Graham & Rawlings, 1991)

As shown above, all four of the conditions which cause Stockholm Syndrome in the hostage

are recreated by abusers within abusive relationships. Although the Stockholm Syndrome is caused in both hostages and battered women by virtually identical treatment, the way these two groups are treated by the outside world is very different (Graham, et al., 1988):

- Public authorities sympathize with hostages, seeing them as having little control over their situation, and media coverage generates public sympathy. In contrast, abuse victims are blamed for their situation: "She deserved it." "Why doesn't she just leave?" "She stays because she likes it."

- Authorities are likely to negotiate for the release of hostages. Hostages are generally released from captivity or rescued by the State. Battered women, however, must find a way to leave their captivity more or less on their own, and rarely are abusers imprisoned -- unlike kidnappers and hostage-takers.

- Negotiations for the release of hostages are not dependent on their proving that they are targets of physical violence nor that they did not desire or provoke it. But unless a battered woman can prove she was subject to life-threatening violence, the legal and criminal justice systems are often unwilling to intervene.

- Governments attempt to capture and punish hostage-takers while abusers are rarely punished, even for decades of abuse, unless the woman or children are killed.

During the ordeal of Flight 847, businessmen changed in a mere ten days. However, research shows that a terrorist captor can achieve the "conversion" effect of the Stockholm Syndrome with a stranger in ***less than 4 days*** using the psychological torture tactics mentioned earlier. *In contrast, a batterer has* ***months or years - sometimes decades*** *-- to use precisely the same tactics to terrorize a victim made much more vulnerable because she loves him.*

As one victim put it, "It's hard to find an enemy who has outposts in your head."

CLINICAL PERSPECTIVE:

THINKING BEYOND THE OFFICE

If you can, help others; if you cannot do that, at least do not harm them.
Dalai Lama

Thinking Beyond the Office*

Working as a therapist is always a challenging undertaking. Our clients are complicated individuals, living complicated lives. For many reasons, some related to the therapy process itself and some to social and institutional prescriptions, we usually work in individual offices and our clients come to us. They bring their pain, confusion, and problems with living with them, and expect that we will be able to help them with our knowledge of human psychological functioning, behavior, and relationships.

Because we sit face to face with an individual, or a small group of individuals, our perspective on our clients' lives is limited by the window our clients provide us. We see these lives through the client's words, posture, appearance, mood, behavior, tone of voice - all the things that make up a person's "presentation" at this particular moment in this particular place. We can expand that window by asking questions and by paying attention to the variations and consistencies that emerge in our interactions. To a large extent our skill as therapists is dependent on our ability to create a coherent, accurate picture of our clients from our office perspective and to present that picture to our clients in a way which helps them find new choices and directions.

Our window is also formed by the professional training we have received. While training programs vary by discipline (psychology, social worker, addiction counseling, etc.) and also to some extent within disciplines by theoretical orientation and training philosophy, they share a common emphasis on the individual or the small group (e.g. the family). This training and our ongoing involvement in our profession provide a framework for organizing our thinking about our work; we take in information about our client and arrange it in a way which allows us to relate this person to what we know about people in general, to define the problem at hand, and develop a plan for treatment. Without this framework we would have no way to make sense out of what we observe and no way to decide on one course of action.

Because we are defined as mental health professionals, our training has taught us to relate our particular clients to our body of professional knowledge through the use of diagnostic categories. These categories were developed (at least in principle) to help us identify patterns of behavior, emotions, and thinking which are indicative of identifiable and distinct problems and which can thus be linked to treatment plans which are appropriate for each particular problem.

The general acceptance of a diagnostic framework in our profession has allowed us to share information about human problems and treatment in a common language. Thus,

when one professional talks about developing a treatment approach for depression, for example, we know what depression looks like and which of our clients fit that category, which ones might be helped by this new treatment approach. We are not forced to reinvent the wheel each time we work with someone new, and we can decide which information about our new client is relevant to helping this person.

However, like any cognitive framework, this mental health approach must produce order in all this complexity by deciding which information is significant and which questions (and thus which answers) are relevant. In doing so, the approach also defines what information is seen as not significant and therefore ignored, and which questions are not asked, which answers are not heard. This realm of the irrelevant and unseen, however, is usually defined by default (defined by what it is not), rather than deliberately and explicitly. This inevitably creates blind spots in our professional thinking, leading us to miss or discard information which really is relevant and which will affect the treatment we give our clients and thus will affect our clients.

The training manual of which this chapter is a part is intended to help mental health and victim service providers work together toward the common goal of helping individuals who come to either one or both of us. We have been working on how to coordinate our efforts, acknowledging that often neither of us has everything a survivor needs. Since what we each have to offer is different, we use different frames of reference for organizing our thinking about what we observe and for deciding on a course of action. Becoming more aware of the roles trauma and victimization play in our clients' "mental health" can help us see beyond our offices, into territory which may have been defined as irrelevant within our professional discourse but which often holds information which leads to a much more useful understanding. To the extent that understanding the problem more completely leads to more effective solutions, we are likely to be more effective in our own treatment plans and to recognize both the need for and the usefulness of services we do not provide. When we expand our awareness beyond our offices, we can expand our own professional framework, and also avoid the error of thinking all of reality can be reduced to what is known, or even knowable, within that framework.

This chapter will start with certain assumptions or guiding principles based on this willingness to see beyond what is professionally familiar:

- First, we work with people, not disorders. If we forget this, we will limit our understanding of our clients by reducing them to what can be contained within any diagnostic framework.
- Second, psychological, physical, and social factors can only be separated abstractly. In our clients' lives they form a cohesive whole. If we want to be effective we cannot forget these interrelationships even if we only work directly within a psychological perspective.
- Third, we benefit from exploring the territory beyond professionally accepted definitions

of relevant knowledge. We can expand our own frame of reference and we will recognize when to make referrals outside our system.

Integrating Awareness of Victimization into Treatment

While most of us are trained to take a psychosocial history as part of the treatment process, often that history is only poorly connected to the diagnosis and treatment plan. Awareness of a past history or the present experience of trauma, abuse, and/or intimidation should have an effect on the way we think about everything we do, and can often mean that the presentation we observe will have a very different meaning and significance than it might in the absence of this history. Unfortunately, all too often the significant integration of the person's past history into treatment decisions is identified with a specific theoretical position (psychoanalytic/psychodynamic). Even when this history is seen as a causal factor in the current "condition," the diagnosis itself and the general treatment plan are often developed solely on the basis of the current presentation and even before any history is taken.

Diagnosis

The diagnostic framework within which most mental health professionals work is codified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). It is intended to provide a set of commonly agreed upon criteria for conditions which can be recognized with consistency and are clearly distinguished from one another. The assumption is that if we can identify a condition accurately we will be better able to differentially apply treatment strategies and techniques, as well as facilitate professional research and dialogue. The DSM's diagnostic categories and the criteria for inclusion in each are deliberately based only on observable signs and symptoms, and are intended to be theoretical, to make no assumptions about etiology, and to avoid being culturally specific.

The usefulness of such a framework is not in question. As a profession we do need to be able to understand each others' references. The DSM categories provide a useful reference point, allowing us to define our areas of agreement as well as disagreement. Even when we do not use this particular conceptual framework in organizing our thinking about our clients, the existence of this "standard" often helps us define our own positions more clearly by having a clear contrasting position and allows us to communicate our position more clearly to colleagues.

However, this professional standard has also been subject to appropriate criticism. For example, the DSM and its categories and criteria are largely the product of a particular

subgroup within the mental health field, psychiatry, and are therefore strongly affected by the assumptions and world view of this medical profession. While other professional groups have had a consultative role in the development of the most recent diagnostic system, the farther these groups have been from the medical experience, the less voice they have had. For instance, social workers have not had the influence that clinical psychologists have had, and voices from outside the recognized mental health professions (such as victim service advocates or community advocates) have only had an impact on the process indirectly, and only to the extent that they have been heard by and have affected the "insider" participants in the development process.

This has clearly limited the final product by restricting the information used in creating it to that which psychiatry as a whole considers relevant and with which it is comfortable, most notably the tendency to see human suffering in terms of diseases and disorders of the individual. Thus the diagnostic categories are not organized in terms of "disordered relationship patterns" (which might lead to categories such as "shame-based disorders" or "disorders related to abusive use of power") or painful individual consequences of social and cultural norms (such as "social class related disorders" or "bias and discrimination related disorders"). These would not necessarily be better diagnostic categories, but they would be equally legitimate ones and would lead to the inclusion of information which is dismissed as irrelevant within a medical perspective but which may be equally relevant to the life experiences of our clients.

We also need to be aware that the development of these diagnostic criteria are not even an objective reflection of a unified medical perspective. The field is characterized by a multitude of theoretical perspectives which inevitably means that the final document is going to be a compromise, an attempt to find a framework which is inclusive and which allows for discourse and common definitions across these varying positions. Also, the debate over categories and criteria reflects the pressure of factors which are outside the realm of professional discourse and which are not acknowledged openly in either the categories or the official discussion of the development of the conceptual framework (such as the social and economic interests of the different professions in the mental health field, and the class and power differences between professionals and clients/patients). DSM-IV and all its predecessors are inherently social and political documents, but the effects of these forces cannot be recognized unless we step outside the limited perspective of the field.

In addition, the attempt to provide a diagnostic system which is not limited by cultural factors has produced a document in which cultural variation is acknowledged only in the introduction to the manual. We are cautioned (in the introduction) that these factors must be "taken into account" (although there are no guidelines as to how to do this) and that we should modify our interpretations of clients' reports of symptoms based on awareness of varying cultural meaning systems. The bias toward minimizing the cultural limits of this

diagnostic system is shown both in the absence of cultural variations in the diagnostic categories and criteria themselves, and in the inclusion of an appendix titled "Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes" as if the rest of the manual were not a cultural formulation.

What are the implications of these professional realities for our work with survivors? **In short, be aware of the limits of our diagnostic system**. Respect the usefulness of its potential for organizing our understanding and informing our decisions, but do not confuse it with a complete picture of our clients' lives, or even psychological experience.

More specifically:

- **Do a history before you assign a diagnosis.** This increases the probability that you will take experiences such as trauma and abuse into account.

- **Always be aware that the diagnosis is only a means to an end, that it helps you as a therapist relate your clients' problems to a body of professional knowledge.** It is potentially useful for both you and your client, but is not adequate as or a substitute for an understanding of your client as an individual.

- **Communicate this limited meaning of the diagnosis to your clients.** Allow them to know that the diagnosis is a useful tool, not a description of them as people. Let them know what it tells both of you about the similarities of their experiences to those of other people, and what it does **not** tell you about the uniqueness of their experience.

- **Use the diagnosis as a shorthand description of a collection of signs and symptoms not as a description of or a label for the person.** Be careful in your use of words, and not just in front of your client. We aren't working with depressives, or borderlines, or even PTSDs. If we force ourselves to refer to our clients as people with symptoms consistent with depression or PTSD we are more likely to stay aware of the full range of factors affecting their functioning and experience.

- **Remember that the context in which signs and symptoms occur affects their meaning and therefore the significance in making a diagnosis.** Confusion in the midst of a traumatic experience has a different significance than confusion without trauma. Feelings of powerlessness in the face of real social powerlessness is not necessarily a symptom of a depressive episode.

- **Use the diagnosis to identify problems rather than to pathologize the client.** This means seeing the strengths and functional aspects of their behaviors as well as the

dysfunctional ones. If you identify your *clients* as dysfunctional you make it difficult for both yourself and them to see their strengths and resources. When we validate the functional aspects of their behavior and the legitimacy of their emotions and needs, we can also identify their problems and dysfunctional behavior in a way which empowers them.

There are several diagnostic issues that are relevant in working with clients who have been abused and/or traumatized. One of these is the use of personality disorder diagnoses on Axis II. Therapists need to be aware that abuse can affect both the way the diagnosis is made and the implications of the diagnosis for treatment. A personality disorder is defined as "an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (DSM-IV, p.629)."

Because by definition they are characterized by persistent patterns of problematic behavior, it is often easy to see these disorders as inherent to the individuals themselves rather than looking closely at the context in which these patterns developed and are maintained. Abuse in childhood, especially if it is prolonged, repeated, and ignored, can lead to the development of patterns of reaction and behavior which are functional in the context of the limited options open to children but become dysfunctional in other contexts. In addition, these patterns become incorporated into the child's view of the world and to the developing sense of personal identity. The children, and later the adults, make the same error that the therapist can make so easily - confusing the adaptations they have made to intolerable situations with characteristics inherent to themselves as individuals.

Once the personality disorder is equated with the person, the diagnosis can have several negative implications for treatment. In many ways, personality disorders represent extreme manifestations of human emotions and reactions. However, the needs of these clients are often seen as evidence of the disorder. The needs thus become symptoms to be eliminated, whether it be the need to be taken care of (dependent personality disorder), for attention (histrionic personality disorder), or for attachment (borderline personality disorder).

Clients often experience pressure to change as pressure to eliminate the self, and even when they are profoundly unhappy with their current situation, self protectiveness will set up strong ambivalence about therapy. Recognizing that the underlying needs are valid, while clearly acknowledging that the patterns developed to meet them are dysfunctional, allows both therapist and client to identify the client with the underlying human needs rather than the "enduring patterns of inner experience and behavior." In this context, naming the

abuse the client has experienced and recognizing the effects it has had can be a powerful way of breaking connection between destructive adaptations and the self. This process can be particularly empowering to clients, since it allows them to see change as taking care of themselves rather than as a betrayal of self.

One other way that the diagnosis of a personality disorder can have a negative impact is that it can lead both therapist and client to focus attention on the client's distorted reactions to events, and thus minimize or ignore abuse or victimization in the present. While this can sometimes be difficult, clients need to be encouraged to recognize abusive behavior and take effective action to protect themselves. Therapists need to be aware that just because a client has learned, for example, to complain constantly (having not been listened to in the past when she stated something was wrong), it does not necessarily mean that there is an invalid basis for the client's complaints. Therapists need to remember that these clients are still vulnerable to abuse and exploitation in the present, and if that is ignored it increases the need to act out their needs in extreme ways.

Some similar concerns arise in using diagnoses related to alcohol and/or drug dependence. Substance abuse often starts as an attempt to self-medicate overwhelming pain. Over time, the person comes to believe that survival depends on using and identifying with the substance use: "this is just who I am; I'm not strong enough to survive without this."

In an attempt to get substance abusing clients to take responsibility for their behavior in the present, many individuals and programs reject any discussion of past abuse (or even present abuse) as avoiding responsibility, denial, or excuse-making. Acknowledgment of their deep emotional pain by these clients is seen as self-pity. However, if the only alternatives given to clients are denial of the addiction or denial of their pain and the real effects of abuse, they essentially have only destructive options - a replay of the situation they've been in from the beginning.

Denial and avoidance of personal responsibility are certainly characteristic features of drug and alcohol addiction. However, one of the difficulties with the diagnosis is that once seen as an addict, everything else about the client may be seen through that filter. A history of abuse and victimization is not less significant simply because the person developed a pattern of substance abuse to cope with the effects. Also, current abuse is not less significant because it happens to someone who is drunk or high. If anything, people who are substance abusing are more likely to be victimized, and the abuse and exploitation may be even more harmful because it confirms the person's negative experience of self and others. To minimize the seriousness of victimization in these contexts is to reduce the person to a diagnosis, to reinforce the sense of worthlessness and powerlessness (as if it's OK this happened to them because they're addicts), and to give the person no constructive way to deal with the effects.

When the seriousness of the abuse is recognized and the reality and validity of the clients' pain is acknowledged, sobriety can be experienced as healing and self-care rather than as punishment. Assuming responsibility for one's own life and behavior can be seen as empowering rather than an admission that s/he has been "acting like a victim." Recovery can and should be seen as a profound act of resistance to the pain inflicted on the person, and in this way it is a refusal to assume blame for the destructive behavior of others. Recovery is **also** a willingness to assume responsibility for the harm we have done to self and others. Clients must be helped to do both, and the reality of the second should not be allowed to invalidate the first.

Safety Issues in Working with Survivors

Therapists working with survivors (and with any client, for that matter) need to be aware that the potential for abuse and exploitation by others is an ongoing reality for everyone. Survivors may be particularly vulnerable to injury in this way *not because they create or seek abusive situations*, but because their ability to recognize danger, to be self-protective, and to defend themselves effectively may be reduced as a result of earlier abuse. Clients should be helped to understand this, and recognize their vulnerability so that it can lead to efforts to protect themselves more effectively (empowerment) instead of self-blame and hopelessness.

Many survivors recognize the pattern of repeated trauma and abuse in their lives, and come to see themselves as having been "singled out" for bad things. This leads to a sense of inevitability, as if something about them makes them "magnets" for destructive people. Often therapists make the mistake of trying to undermine this way of thinking by arguing that the survivor is not special in this respect, that bad things happen to everyone. However, this approach may have the unintended effect of invalidating the survivor's accurate perception that victimization has become a pattern and minimizing the significance of the pain that is experienced. Survivors need to recognize and take seriously any abuse or threat of abuse as a first step toward changing this pattern.

- **Don't be afraid to acknowledge a survivor's continuing vulnerability to abuse and victimization.** What survivors need is the clear message that this vulnerability is in part a negative side effect of earlier efforts to protect themselves from the pain and fear of traumatic experiences and in part the result of the social distribution of power. They can thus be empowered to make changes without blaming themselves for the vulnerability itself.

Clinical Perspective: Thinking Beyond the Office

- **Do a careful assessment for current abuse and exploitation, and repeat this throughout the therapy process.** Don't assume that if abuse isn't occurring at the time of the initial assessment that it isn't occurring later. Don't assume that your client will volunteer this information, or accurately represent its seriousness.

- **Don't accept clients' assessment of danger and/or harm at face value.** Survivors, especially those in currently abusive or threatening situations, often deny or minimize danger or injury as a way of managing their own feelings of vulnerability. When clients say that the situation isn't that bad, they may be reporting their assessment of the treatment they deserve or the degree of their emotional numbing more than reporting the actual danger. Ask specific questions, and point out the discrepancies between their reports of actual behaviors or events and their evaluations or interpretations of those behaviors or events.

- **Make safety from harm by others a first goal in therapy.** In order for survivors to deal with prior trauma they have to begin to believe they will not be overwhelmed by the emotions associated with that trauma. Part of this belief is based on knowing that the abuse belongs to the past rather than to the present. If the survivor is being abused currently, or there is a real threat of abuse, without effective ways to deal with the current situation, the survivor may actually be overwhelmed and therapy will end up confirming all the fears that have held the dysfunctional patterns in place.

- **Make referrals and help clients to make use of community resources. As a therapist you cannot protect clients and you should not try. Nor should survivors be encouraged to think they can handle dangerous situations on their own. Know what is available in your community and how to help your clients gain access to these services. (Victim service providers are good sources for this information.)**

- **Do not encourage clients to make themselves vulnerable in situations in which they really have no control.** Do not encourage clients to confront abusive or exploitative people if there really are no effective constraints on the perpetrator's behavior or if the clients really have no way to escape or protect themselves. **Do not involve perpetrators in the survivors' therapy if the survivors are still vulnerable to attack or victimization once they leave your office or if you cannot protect the survivors from harm (physical, verbal, or emotional) in your office.** This means that most couples counseling in cases of domestic violence or family counseling involving perpetrators and child victims should involve separate therapists for victim and perpetrator, and risks should not be taken with the victim's safety in the interests of a systems approach to family dysfunction.

Clinical Perspective: Thinking Beyond the Office

Self-harm or self-injury/mutilating is often an issue in the treatment of survivors. It is a distressing behavior, often as much or more for the therapist than for the client. Self-injury can take physical forms, such as cutting or hitting, or it can take internal forms, such as internal verbal abuse or the intrusion of painful images or memories. As self-destructive as these behaviors appear to be (and are), they have usually developed as a way of managing even more painful injuries and emotions and are therefore difficult to give up. Clients must be given alternative ways of meeting this need if they are to give up behaviors which have given them at least some protection.

Physical self-injury can be the hardest for therapists to tolerate, and it is easy for them to communicate their panic to the clients. This can both frighten and shame the clients (although this is rarely the therapist's intent), and lead to efforts to hide the behavior to protect or please the therapist. This may make the therapist more comfortable but does nothing to help the clients.

Internal self-injury can be just as self-destructive but is obviously even easier to hide. It is common in survivors and can serve the same variety of functions that physical self-injury does (e.g., self-punishment, either stimulation or numbing of emotions, a trigger for dissociation, reinforcing a sense of control and strength, etc.).

Survivors are often frightened and ashamed of this behavior, seeing it as evidence that they are crazy or bad. Efforts to "control" it by trying to stop usually end in failure, increasing the fear and shame. Survivors often feel sure that if anyone knew they would be rejected, or worse. They usually cannot see the connection between the trauma and the self-injuring behavior, and so it feels like there is no reason for the behavior other than their "craziness" or "masochism."

Self-injuring behavior can be a serious threat to survivors' safety, even when it is not suicidal in intent. When it is used to manage emotions and intrusive thoughts and images, the behavior may escalate dangerously in times of greatly increased stress or crisis. If it occurs in the context of dissociative episodes, survivors may have a reduced awareness of their actual environment and therefore a reduced capacity for self-protective responses. Internal, non-physical self-injury can be equally dangerous. It leads to repeated trauma, with all the negative psychological effects of any trauma. Because it almost always involves a degree of dissociation, it reduces awareness of the external environment and increases the survivor's vulnerability. It may also lead to extremely risky behavior, such as driving in an impaired condition. Therefore the behavior should be clearly and directly approached as a safety issue.

- **Do a careful assessment for self-injury, both physical and psychological.** This

assessment should include both an evaluation of the behavior and an evaluation of the behavior's functions. This is the first step in treatment, and it communicates to the survivor that the behavior is neither meaningless nor crazy.

- **Do a careful evaluation for suicide risk as well as self-injury.** This will help you distinguish between behavior which is self-destructive *in intent* and that which serves other purposes but in self-destructive ways. Both are serious problems, but may require different interventions.

- **In treatment, focus on finding alternative ways to meet the functions served by the self-injury, not just on eliminating the destructive behavior.** This keeps the focus on positive change and allows both therapist and client to build on the survivor's strengths and impulses toward self-protection. Direct assaults on just the behavior almost always lead to failure, frustration, and shame (for both therapist and client) and can severely undermine the therapy.

- **Recognize your limits.** As with harm from others, the therapy relationship cannot provide a protective cocoon for survivors. Your role is to help them find and use the support systems available.

Medication Issues in Working with Survivors

Medication can play a useful role in the healing process for survivors since victimization and trauma have physical as well as psychological consequences. However, when all painful or uncomfortable emotions are automatically defined as symptoms of a mental disorder, medication may be used inappropriately in ways which actually hinder the resolution of traumatic events. In addition, survivors may be given the message that there is something wrong with them (i.e., they **should** be reacting differently) when emotions and behavior are evaluated only as symptoms.

Strong, difficult emotions such as sadness, fear, and anger are human responses to painful, frightening events and need to be experienced, identified, and given meaning by survivors. However, if these emotional reactions have persisted over extended periods of time without the survivor having the opportunity to express and understand them, they may overwhelm the survivor's physical and psychological ability to respond to people and events in the present. The distinctions between past and present, danger and safety, abusers and non-abusers can become blurred. For example, the sadness and grief that is an appropriate response to significant loss, if unresolved, may undermine the body's ability to maintain a stable mood and the survivor may become not just sad but depressed.

At such times medication may provide not only relief but may help the survivor sort through emotions more effectively and recognize the source of the original grief. Similarly, chronic hyperarousal may interfere with the body's ability to regulate arousal, and the survivor may experience anxiety and panic that is not clearly connected any more to present events. If the therapist does not recognize the possibility of such physical consequences of trauma, clients may become unnecessarily frustrated and discouraged in therapy.

On the other hand, the current emphasis in much of the mental health field, especially among psychiatrists, on the biochemistry of mood and anxiety disorders often leads therapists to focus on physical symptoms and to label disturbances in mood or emotion as "biochemical imbalances." This often leaves survivors believing that their reactions to abusive experiences and situations are caused by their biological inability to "handle stress." It is too easy to go from this belief to a treatment focus on changing the survivors rather than on helping survivors change their situations, and medication can become the logical way to eliminate or change the survivors' reactions. Within this framework, behavioral, cognitive, and emotional interventions become only additional ways to change a disordered client.

While it is unreasonable to ignore the physiological changes that can and do result from victimization and trauma, there are several ways therapy can become less effective if our perspective on our clients becomes too heavily biological. We can easily collude with survivors' (and society's) self-protective denial about the reality of victimization and abuse, supporting their efforts to minimize the seriousness of the abuse by maximizing their sense of weakness and "dysfunction." We can turn the goal of effective coping into increasing the capacity to tolerate the effects of abuse, powerlessness, injustice, and so on by focusing on managing mood and emotional reactions to events.

If we see human pain primarily in terms of biology, we are also less likely to ask questions about why these clients might have become emotionally or physically overwhelmed. We are less apt to consider the answers to these questions as relevant to treatment, and thus less prone to direct our clients' attention to changing the problems in their lives, or to recognizing the problems in society as a whole. Problematic behavior patterns are also less likely to be understood (by both therapists and survivors) as positive attempts to manage the effects of abuse if the emotional reactions themselves are seen as symptoms of a biological disorder. The strengths and resources (both physical and psychological) of survivors are likely to be ignored or minimized.

Thus, the biological effects of victimization need to be taken into account, and medication may be a useful part of treatment. However, it cannot be the focus of treatment when victimization and trauma are involved without masking the meaning of our clients' emotional responses.

- **Evaluate the biochemical factors in your clients' experience only as part of the total picture, so that emotional and cognitive responses are not seen in isolation.** For example, a family history of depressive episodes may be important because it helps us understand the way trauma may affect this particular survivor, but it does not make genetic vulnerability to depression the cause of the survivor's problems, nor should it be allowed to distract therapy from trauma issues or to make the survivor's pain seem less appropriate or "unhealthy."

- **Medication should be considered when the survivor's depression, anxiety, or other emotional responses overwhelm the ability to protect themselves (from self-harm or injury by others), or the ability to use psychological resources to process the trauma and make constructive changes in the environment.** It should not be used to avoid painful emotions in all circumstances because this would prevent real confrontation with the abuse and/or trauma.

- **Know your psychiatric referral base.** Make sure whenever possible that the psychiatrists to whom you refer survivors are familiar with victimization issues, and are willing to work with you as the therapist providing psychological treatment. Also, make sure the psychiatrists understand the importance of other service providers (such as victim services providers) and are willing to work with them.

Evaluating Outcomes in Therapy

The way each individual therapist evaluates the outcome of the work with a client depends a great deal on the therapist's theoretical framework. However, there are some general principles which apply to psychotherapy work with survivors and which cross disciplines and theoretical perspectives.

- **The evaluation of outcome always needs to look at the survivor as a whole person.** The reduction of painful or uncomfortable emotions cannot be evaluated as positive if abuse or victimization is continuing or if past trauma is still being re-experienced internally. Under these circumstances the absence of emotional pain would indicate that adaptation to the trauma was still requiring responses that maintain your client in a victim position (such as dissociative reactions to abuse or the psychological numbing of depression which would interfere with taking effective action to end the abuse).

- **A positive outcome in therapy should include re-establishing survivors' connections to the community.** This involves a sense of belonging, of being supported by a network in which their experience is recognized and taken seriously. It also involves a sense of empowerment, of being able to take effective action which has an impact on others. This sense of empowerment incorporates not only an ability to act on their own behalf, but also a sense of commitment to change in their communities, although this commitment can take many forms. A therapist truncates survivors' healing by treating it as only an internal, psychological process.

Therapy in the Context of the Survivor's Life

A therapist working with survivors tries to create a safe space in which survivors' voices can be heard, often for the first time. The therapy relationship and the actual meeting space are thus to some extent protected from the stresses of the "outside." However, the healing process itself is not and cannot be protected in this way. It occurs in the context of the survivor's entire life, and is affected by all the stresses and needs which are part of that life. Therapists must therefore recognize that since healing, rather than therapy, is the ultimate goal, these stresses and needs must be addressed if therapy is going to be helpful to the survivor.

At the same time, however, the therapist's usefulness to the survivor will be reduced if the therapist tries to deal directly with all these issues. The therapist would be taking on more than any one person can do, and therefore inevitably leave too little time and energy for therapy. Also, if the therapist becomes too directly involved in other areas of the client's life, the therapy relationship can no longer be as protected and safe as it needs to be. The therapist needs to find a way to keep therapy clearly connected to the rest of the survivor's life, and at the same time protect therapy's unique place within that life. This necessarily means helping clients find and maintain other relationships in which many needs and stresses can be more effectively addressed.

While the therapist cannot effectively assume responsibility for addressing all of a client's needs, the therapist must know what these needs are, how they are affecting the client's life, and how to help the client address them effectively. Not assuming responsibility for meeting these needs is **not** the same as ignoring them. One of the most effective links to effective help is the victim services provider, and therefore the active involvement of these provider networks can create a supportive environment for therapy.

Survivors may have any number of unmet needs and stresses which negatively affect the quality of their lives. More specifically, these stresses can undermine the healing process, keep the client locked in a cycle of revictimization, block healthy growth and development,

and limit the client's ability to nurture those who are dependent on the client (especially children, who become caught in the victimization process without the ability to act on their own behalf). Basic needs such as food and shelter are often provided by abusers. Even when these are not directly linked to tolerating abuse, the lack of basic necessities, or the threat of losing them, is obviously going to increase the survivor's feelings of hopelessness and powerlessness.

Survivors, like everyone else, also need to know they have access to physical and legal protection from victimization. Unfortunately, the justice system does not have a good record on providing this protection to many of those most vulnerable to victimization. Having an advocate who is familiar with these social institutions and who can facilitate their effective use is often critical, and this advocacy is the role of the victim services provider.

- **Be aware of, and help your clients be aware of, needs which you are not able to address directly.** Survivors are often not good at identifying these needs, since they may have learned to tolerate or deny deprivation and insecurity in order to reduce pain and anxiety.

- **Be aware of community resources and make your clients aware of these.** This does not mean you must become the link between the client and these services, but that both you and the client maintain an awareness of the client's connections, or lack of them, to community providers and resources.

- **Do not be afraid to facilitate these connections.** You do not need to step out of your role as therapist to believe these needs are important and to act in a way consistent with that belief. You can facilitate the survivor's use of community resources by addressing psychological barriers to reaching out to safe and supportive individuals and groups. You also need to recognize that your social position (both personal and professional) may give you more influence and access than your client (e.g., doctors may listen to you more seriously because of your professional status). See yourself as part of this larger social network and participate in it in ways that are useful to your clients.

- **Work with your client to find the balance between active collaboration with other service providers and protection of the privacy and safety of the therapy process.** This balance will be somewhat different for each survivor. However, it is up to you as a therapist to understand how therapy differs from other helping relationships and to be clear (with yourself and your clients) about what you as a therapist can and cannot do for your clients. You thus communicate that you can be relied on without setting up unrealistic expectations for therapy or setting up other providers as competitors.

Clinical Perspective: Thinking Beyond the Office

When thinking about community resources for clients, it is important not to restrict thinking to social agencies or institutions which are defined as "helpers." Other social institutions and groups, such as churches, unions, and neighborhood groups, can provide important experiences of validation, support, and empowerment. (Be aware that these groups may provide opposite experiences as well for many survivors.) Because survivors have often learned to keep their experiences and needs secret, they may have little practice in matching specific needs with the resources offered by others. They may even have difficulty differentiating among their many needs.

In these circumstances their own neediness and the helpfulness of others may be seen in very black and white terms; dependency/help-seeking jumps back and forth between zero and 100 per cent. Every relationship (sometimes every interaction) can become a test (either consciously or not) of the survivor's own right to need help and/or of the other person's ability to help and be trustworthy. When this occurs, survivors who do risk reaching out often find themselves experiencing repeated disappointment and betrayal even with those who are trying sincerely to help. Learning how to make more differentiated requests for help and to recognize the value of what a particular person has to offer can transform the survivor's life from a series of disappointments into a network of specific sources of support. Conversely, learning to recognize the limits of even the most supportive people can help protect the survivor more effectively from victimization in the future, because trust does not have to be either an all or nothing process.

Understanding the difficulties that survivors often have in differentiating their needs and their trust is vital to therapists working with them. We are much less likely to become defensive in response to our clients' disappointment, anger, and frustration with therapy and with us as therapists if we understand how necessary it has been for them to avoid "mistakes" in trusting or needing others. It becomes easier to communicate that it is safe to rely on us as therapists without getting caught in trying to prove that we will never disappoint or fail them (an impossible task since they have needs we cannot meet).

Recognizing the difficulties involved in learning to trust others in less than black and white ways is also very important if we are going to work collaboratively with other providers and with the survivor's support system. While it is critical to validate the client's experiences of hurt, disappointment, anger, and so on in dealing with the other person, this needs to be done in a way which does not distort the total relationship. Survivors may need help evaluating relationships in ways which take into account both positive and negative experiences. They need to feel empowered to take negative experiences seriously enough to do something about them, but they also need to know that all relationships involve negative experiences and that healthy relationships can deal with hurt, anger, and other difficult emotions. If we as therapists jump too quickly to "defend" our clients and reduce

their experiences with others to a defensive black-and-white perspective, we may inadvertently reinforce the distorted view of reality which the original victimization created.

The same principles are involved in helping clients establish a support network among friends and family. If therapists see other people in the survivor's life only in terms of dysfunction or of their potential for harm, then clients are put in a position of either defending them (against us) or becoming isolated from them. Also, by leaving so little room for other people to make mistakes and be imperfect, we may make it difficult for clients to recognize or acknowledge their own mistakes and imperfections without overwhelming shame. This is **not** to say we should minimize or excuse abusive or destructive behavior, but we need to remember that human relationships should not be oversimplified.

We also need to help survivors learn how to draw the best from the friends and family on whom they rely. Often these supportive people are left floundering in the dark because clients can't explain what they need or what they are experiencing. Survivors may be afraid or ashamed to talk to others, or may just not know how. Therapists may recognize that friends and family are important but often make unjustified assumptions about the way support is available to individual clients. For instance, many therapists assume a survivor's husband "should" be her closest emotional support, when it is often a friend or sister. If a therapist considers involving immediate family members in therapy for survivors, interventions involving significant others with less socially recognized ties should also be considered. The other person may be provided with education and information which would be helpful in the relationship and therefore to the survivor.

Specific relationship problems related to the unrecognized effects of the earlier victimization can be addressed in ways which empower the survivor and also model effective communication. Other people may be able to help the clients identify and use resources available in their social and physical environments of which the therapist is not aware. Helping others who care about the client find ways to effectively provide support is often a great relief to both the survivor and the other people. Also, involving close friends as well as family in the healing process can help break down the isolation created by shame and can strengthen the experience of emotional closeness for both the survivor and the other person.

However, care needs to be taken when involving other people in a survivor's therapy. The therapist needs to consider both the impact on the therapy relationship and on the client's life outside the therapy session. Safety concerns always need to be addressed (see previous section on safety). Also, clients need to feel they have control in the therapy relationship and that others, well-intentioned or otherwise, will not supplant the survivor in the working relationship with the therapist.

- **Work with the survivor carefully in planning any involvement by others.** Listen to your clients' descriptions of their social worlds. Set goals with which your clients are comfortable and be as specific as possible.

- **Be very careful to address issues of confidentiality.** Your client should feel in control of what is revealed and under what circumstances.

- **Remember, others are being enlisted as your client's allies, not yours.** Do not allow others to change the primary partnership that exists between you and your client.

Another source of social support that may complement individual psychotherapy is group work - support groups, self-help groups, and therapy groups. Groups can do many things that individual therapy cannot. They can reduce the feelings of isolation and shame that are so common among survivors, giving them a place to both speak and listen, to discover both their commonalties and uniqueness. Groups also allow survivors to experience themselves as both helping and being helped by the same people, thus creating an atmosphere of mutual empowerment. Groups can also increase a survivor's awareness of personal strengths and resources very effectively. In many groups there is an expectation that people will be more open and direct than is often the case in other social settings. Survivors often receive feedback from other participants which can challenge assumptions and attitudes that have their basis in defensive reactions to past abuse.

Not all of these types of groups function in the same way, however. While these labels are sometimes used differently, in general the types can be distinguished both by their structure and their goals. Therapy groups are led by trained therapists, who assume a different kind of responsibility for monitoring and directing the group process than other participants. Therapists also do not participate in the group interactions in the same way other participants do, therefore, since they should not allow themselves to get so focused on their own issues and reactions that they cannot observe and respond to the whole group's dynamics. This often allows therapy groups to address more difficult, potentially disturbing issues in more safety, since interactions among members are being observed and can be stopped, examined, and redirected when necessary. Therapy groups also are more likely to have an explicit goal of facilitating change, and members expect to be challenged to examine and change their ways of thinking, behaving, and feeling.

Support and self-help groups vary greatly in their structure and can often be defined generally only by the lack of a therapist leader. Support groups may or may not have a designated facilitator, but that person does not usually have the same responsibility for the group's process as a therapist would and may participate more fully as an equal group member. Self-help groups do not usually have a designated leader or facilitator, although

group members may take on responsibility for specific group functions. The groups may have consistent participation by the same members, or may have no such expectation of commitment to attend regularly, functioning more as "drop in" groups that members use when they are in need or want. The goals of these groups are often less specific, and may vary greatly among members in any specific group. Often there is more emphasis on support rather than on promoting a specific type of change or growth. Because responsibility for the group's functioning lies squarely with the members, these groups can often be very empowering, but may also be a less protected environment for dealing with issues which feel overwhelming or which make the individual feel very vulnerable.

Therapists should help each client evaluate potential group participation in terms of the individual's needs and goals. Just like relationships with individuals, relationships with groups can be more or less helpful, and can even be destructive or abusive. Thus, the survivor has really two types of questions to consider when thinking about whether to participate in a group. Does the survivor have needs which could be potentially addressed in a group, and if so, what type of group would meet those needs best? And does this particular group, with these particular members, function in a way which works for the survivor? Because a group setting is often very frightening to survivors who are used to hiding their thoughts and feelings, the individual therapist can often be very helpful in both facilitating this connection, and in helping survivors evaluate their participation in a way which validates their experiences **but** does not reinforce their negative expectations (of themselves or others) which are based on past abuse rather than the actual group behavior.

A special issue which comes up when looking at therapy in relation to other parts of the survivor's life is that of the therapist as an "expert witness" in legal proceedings involving the survivor. Therapists need to be very aware that the structure, goals, and rules that apply in psychotherapy are very different from those that apply in the legal arena. Legal proceedings are based on an adversarial process intended to resolve conflicts either between individuals or between the state and an individual. The goal is most certainly **not** healing. Therefore if therapists decide to become a witness in a legal proceeding, they need to recognize that their role as a healer, and even the effects that the proceedings may have on the survivor, become irrelevant. Therapists who make this choice must recognize that they have become participants in an adversarial process, and that they will be challenged in ways which may have little or nothing to do with their therapeutic relationship with their clients. The rules that govern what is relevant in a courtroom are very different that those that govern what is relevant in the therapy room.

- **Don't go into any legal proceeding unprepared and uninformed.** Know what it is you will be expected to be an expert on - your client's psychological functioning, the

effects of abuse on behavior in general, some other specific question. You need to seek advice and information.

- **Being an expert witness is not the same as being an expert therapist.** An expert witness must also understand what it means to give legal testimony, not a topic typically covered in a therapist's training. You can do your clients more harm than good if you think that your knowledge of psychology is enough to make you a good witness. **If you are interested in doing legal advocacy as a therapist, get specialized training.**

- **Exposing the therapy relationship in a courtroom will change the relationship.** Sometimes these changes are predictable, sometimes they are not. Often there are at least temporary negative changes, and it may be difficult to restore the sense of safety around the therapy relationship. Discuss this issue clearly with your clients. Make sure that both of you understand that you may be asked tough questions which you will be required to answer, that the questions will be asked in ways which serve the purposes of the two opposing sides, not in ways which necessarily promote a full understanding, and that you will often not be given an opportunity to qualify or explain your answers.

The Therapy Relationship

The relationship between the therapist and the client is really the cornerstone of all good therapy, and the principles of all good therapy also apply to therapy with survivors. However, there are some special issues that may come up in working with survivors which affect the way those principles are applied.

Believing Survivors

Survivors have often been forced to keep secrets in order to survive, either because they or others on whom they depended were directly threatened with harm if they did not or because they believed that speaking out would lead to harm, rejection, or shame. Over time, they may have difficulty believing themselves, since there is little or no external validation for their perceptions or memory. For this reason, their attempts to speak about their experiences are often extremely difficult and they will monitor the reactions of their therapists carefully for signs that they are not believed.

A therapist who works with survivors must be prepared to listen carefully and with respect to their accounts of their experiences. However, believing that clients are telling the truth about their experiences is not the same as accepting their perspective as complete or their interpretations of events as objective reality. We do our clients no service by accepting

uncritically everything they say, since we would often end up reinforcing the distortions they have developed to protect themselves from overwhelming pain or fear. For instance, survivors often believe that they are somehow responsible for abuse they receive at the hands of trusted others such as parents. Survivors may believe that parents were abusive because they were trying to correct bad behavior; that the abuse was actually an indication of parental love. Believing this may have protected them from having to face the fact that they were dependent on adults who were actually dangerous.

Therapists must help survivors speak of all the pieces of their experience and find their truth in the total picture that emerges. Some of that picture may continue to contain uncertainty, since there will always be some things which cannot be known or understood completely. Survivors need to learn to trust themselves to know and speak their own truth, not to trust us to tell them the truth of things of which we have no direct knowledge. If we recognize that there are inconsistencies in their interpretations, or if other possible interpretations have been ignored, we help them find their truth by pointing this out.

This is true for obvious distortions such as believing abuse is an indication of love; it is also true for assuming the only alternative is that abuse indicates hate. At the same time, every interpretation and assumption survivors make tell us something about the reality of their lives and experience (e.g., why would a child need to deny any anger with an abusive parent?). We help our clients to listen to themselves by listening carefully and respectfully to everything they say and not rushing too quickly to certainty about an objective truth.

Commitment to Clients

Working with survivors, especially those who have experienced victimization in childhood and/or repeated victimization, may require an investment of time and energy which is somewhat different from that required by other clients. If we encourage survivors to face the full psychological and emotional reality of their victimization, we are also de-stabilizing the systems they have developed to manage their emotions. They need to know we are there to help them through the transition period until new systems have been developed. Especially during crisis times, this may mean having more flexibility about meeting times, phone contacts, etc. There may be an extended time in which we are the only ones with whom survivors feel safe to speak the truth, and therefore we will be a critical source of validation when they feel doubt and fear.

We also need to recognize that we cannot assume responsibility for single-handedly changing survivors' negative experiences. We cannot be available at all times, always able to meet their needs. The clearer we can be with our clients about what we can and cannot

do, the less likely we are to leave them feeling like we have betrayed the trust we promised. However, it is also important that we make it clear that their needs are legitimate, even if we are not able to meet them all, since survivors have often been given the message that their needs are unreasonable (or even that any needs are unreasonable). Finding the balance between the flexibility they require and recognizing our own limits can be difficult but is important. We should discuss this issue openly, and as often as needed, with our clients. Also, consultation with supervisors and colleagues who have experience working with trauma and abuse is very important in maintaining this balance.

Within many traditional approaches to psychotherapy, therapists are encouraged to maintain a "neutral," emotionally uninvolved stance in relation to clients. "Services" are provided in ways that are regulated by the therapist alone, and attempts to change these rules by clients are often interpreted as "manipulative." (The diagnosis of borderline personality disorder is often both the source of and justification for these interpretations.) However, this approach to therapy can have negative consequences for survivors, for whom lack of control has been associated with injury and violation. Survivors need to know that they have influence in the therapy setting and that they have an effect on the therapist as a human being in order to feel safe and begin to develop trust. This does not mean that they need to be in complete control, only that they need to know their feelings and needs are being taken into account. Therapists need to be comfortable sharing control in working with survivors.

Showing emotions in the context of human reactions to the survivor's experience can also be an important source of validation for the survivor, and a highly effective way of modeling healthy ways of expressing emotions. When working with survivors, therapists who feel a strong need to control all emotional expression may end up putting more energy into protecting themselves than into attending to their clients, since much of this work is emotionally difficult. Because their trust has been so violated by others on whom they felt dependent in the past, survivors often assume the worst in their interactions in the present. For this reason, they may need more feedback about what their therapists are thinking and feeling than would be true for other clients. This feedback can also be an effective way to begin challenging distorted perceptions and beliefs.

Survivors may also be labeled "manipulative" if they attempt to control the therapy in indirect, covert ways. It is important that therapists recognize that this indirectness has often been developed as the only safe way to influence their social environment. If clients have "hidden agendas" in their interaction patterns, it may be because staying hidden was essential in their efforts to survive; to meet the needs that could not be addressed safely in more open ways.

When therapists interpret clients' behavior as attempts to control the therapists rather than

as the clients' attempts to meet their needs the only way they know how, the therapists are more likely to react defensively and to set up a struggle for power in the therapy. If the therapist feels that this covert process is occurring, it is much more effective to redirect the interaction by helping the client identify the needs that are being addressed this way, and then deal with these needs more openly and directly. This not only reinforces the sense of mutual respect and control, undermining any struggles over power, it also models new ways of interacting and exerting power that the client can use outside the therapy setting.

The realities of social services in this country provide other challenges to a therapist's work with survivors. Many therapists work in settings which do not give them many options in the work they do with clients, severely limiting the frequency and timing of sessions, the access clients have to their therapists between sessions, the kinds of therapy that can be provided, and so on. Therapists who have to work within these restrictive conditions can help clients identify and validate all their needs, can support their efforts to meet some of those needs in other settings, and can advocate for clients within the therapists' agencies and with funding sources. In these circumstances, coordination of services with victim services providers can be especially important.

Though limited, the psychological services therapists can provide in these situations can be useful in and of themselves, and may help empower survivors to take their experiences and needs seriously and seek out additional help. However, recognition of the inadequacy of these services can be very difficult for therapists, who may be left feeling disempowered and discouraged. Just as for our clients, it is important for us to seek out support for our work, validation for our perceptions, and the empowerment that activism in the community can give us.

The Effects of Personal History on the Therapy Process

This topic is usually addressed in terms of transference and countertransference. However, these words have been used in very imprecise ways in the professional literature. Originating in psychoanalytic theory, transference referred to the client's tendency to react to the therapist in ways that unconsciously identify the therapist with significant others in the client's life. Countertransference is the same process, but involving the therapist's reactions to the client. The words are currently used much more generally by those who do not necessarily have a psychodynamic orientation to refer to the way both client's and therapist's personal histories affect their perceptions of and reactions to each other.

Because the work with survivors is often emotionally intense and requires so much openness to emotional experience on the part of both client and therapist, it makes sense

that **both** are likely to feel quite vulnerable. For survivors this means that defensive strategies that protected the survivor in the past are going to be used in the therapy and with the therapist. Clients try to fit their therapists into the conceptual and emotional frameworks they have developed over the years, giving their therapists roles that are based on the survivors' abusive histories. Some of these roles can be quite flattering to the therapists, and can provide a great deal of emotional gratification.

Therapists can be seen as rescuers, strong and decisive. They can be seen as perfect, nurturing parents; as kind and tolerant lovers; as powerful authority figures; as brilliant, intuitive seers. It is critical, for the sake of both the client and the therapist, that the therapist recognize these perceptions as expressions of the survivor's unmet needs, and not confuse these perceptions with their self-identification. Accepting these perceptions in self-gratifying ways is ultimately harmful to the clients, at best leaving distortions unchallenged and at worse setting them up for yet another betrayal by someone on whom they had a right to depend. However, telling survivors that they are "wrong" and that their perceptions are invalid (only transference) only encourages them to hide these perceptions and rarely changes them, pushing them underground in the therapy interactions. Helping clients use these perceptions and wishes to understand their past experiences is another way of recognizing the ongoing effects of earlier victimization, of validating their experience without reinforcing the problematic adaptations they have had to make.

Sometimes the roles that clients impose on therapists are not so flattering. Many survivors have learned to protect themselves by staying on the alert for injury or betrayal. They may feel less vulnerable seeing the therapist as an uninvolved "professional helper" for whom the survivors are just another job. They may see therapists as weak and ineffective when they cannot make everything better quickly for their clients; as rejecting and uncaring when they set limits or are not immediately available; as critical and punitive when they give any "negative" feedback; as sexually seductive when they express caring or concern.

Perhaps the most distressing role for therapists who have worked hard to establish trust and safety with their clients is to be seen as abusive, to be identified with the survivors' abusers in any way. It is very difficult for therapists not to respond to these perceptions defensively, feeling hurt and angry, arguing their innocence. As with the more "positive" distortions, therapists must be able to see these confusions for what they are, and help clients recognize how victimization has become incorporated into their understanding of themselves and others.

It is important to note that awareness of transference processes should not be used to deflect and explain away all negative feedback we get from clients. If clients have complaints, we need to listen carefully and respectfully. We **do** make mistakes, and when

we do we need to acknowledge them and apologize. This is not only ethical behavior on our parts as therapists, it is also an important way of helping our clients learn how to trust their ability to recognize injury in the present. Often when clients have complaints about us or our behavior, there is both a real problem in the present and a transferential interpretation of that. We need to help our clients sort these out and find effective solutions.

Just as clients have experiences and needs which affect the way they react to the therapist and the interactions in therapy, therapists bring their experience to their interactions with clients. Therapists need to be constantly aware of the potential for our own experience to affect our interpretations and emotional reactions. Do frustration and "setbacks" in therapy trigger feelings of hopelessness or doubts about our competence, leading us to seek reassurance from our clients that things are going well in therapy? Are we so uncomfortable with being seen in sexual ways by our clients that we cannot address our clients' sexual feelings or thoughts? Are we afraid of being taken advantage of, and therefore react defensively to our clients' expressions of neediness or disappointment? Do we need our clients to like us so much that we discourage expressions of anger with us or avoid confrontations when they are needed? These are just some of the ways that our own issues can be brought into our work, interfering with therapy. A relationship with a supervisor and/or colleagues whom we trust with personal information is important in examining these reactions in an ongoing way.

Working with survivors can have special significance for therapists who are also survivors. They may identify strongly with their clients, and care deeply about their clients' healing and recovery. This common experience can be helpful in many ways for both therapist and client. It can facilitate both understanding and empathy on the part of therapists.

If the therapists have experienced their own healing, it can powerfully reinforce feelings of hopefulness which are communicated to clients both directly and indirectly, and which can support the therapists through the difficult periods in therapy. However, it is really important that therapists be able to distinguish their own experiences and those of their clients. If a therapist's identification with the client means the therapist's own sense of safety can be undermined by the client's victimization or difficulty making changes in abusive relationships, then a therapist is likely to feel anxious and insecure and communicate this doubt and fear to the client. If a therapist's own anger at her/his abuser is allowed to be directed at the client's abuser, the client's anger may remain hidden or get distorted, or the client may fall back on a defensive protectiveness of the abuser.

It can also be distressing for a therapist, who is also a survivor, to be perceived as abusive by a client that the client's transference cannot be addressed. Therapists who are survivors need to know their own limits in terms of how much stimulation of their own pain and fear they can tolerate without becoming defensive in ways which make therapy impossible. They

need to be willing to balance their desire to help other survivors with respect for their own needs.

Social Roles and Expectations

Social roles, the culturally defined sets of behaviors associated with particular positions in society, affect the way all of us interact with one another. We often use these social definitions to guide our own behavior and expectations of others without conscious awareness we are doing so. We may sometimes actively reject aspects of these definitions, expanding our perceptions of others beyond the restrictions of their assigned roles. Usually we are doing both. Whichever attitude we assume at a particular time, we cannot escape the influence of our culture since we must deal with it whether we resist or accept its prescriptions for ourselves and others.

The ever present reality of social roles is an important consideration in all therapy, since the basis of therapy is the interaction between two individuals who exist within particular cultural contexts. Usually discussions of this issue encourage therapists to be aware of the cultural and social position of clients, and how these factors affect the clients' behavior, thinking, and emotional reactions. While this is certainly important, it is just as important for therapists to be aware of **their own** social and cultural context, and the way these affect **their** behavior, thinking, and emotional reactions.

Often those who participate in the status and privilege of culturally dominant positions (who are white, middle or upper class, male, or heterosexual) are unaware of the extent to which their own roles are just as culturally determined as those of groups who stand out as different from the culturally dominant norms.

Both "normal" and "different" are culturally determined and both need to be examined by anyone who wants a comprehensive understanding of another person's experience. It is important to remember that even identification with a particular group is at least in part a question of social assumptions and norms (for example, an individual whose genetic heritage is one-tenth African and nine-tenths European would still be identified as African American by most people in our society; another person who is one-tenth Irish and nine-tenths German would be unlikely to be defined as Irish American). Also, social roles are usually talked about in terms of group **differences**; they actually define similarities as well.

In the arena of social roles we are rarely if ever dealing with "different but equal." Social

groups are arranged in complex patterns of relative social status. Status is an expression of a particular socially defined group's perceived social value and power in relation to other socially defined groups. Social value and power are expressed in a wide variety of ways: the group's share in the distribution of limited resources; the incorporation of a group's interests into social policy; the visibility of a group's perspective in the media and the arts; and so on.

The behavior of individuals is often judged in relation to the status of the group with which they are identified. For example, becoming a medical doctor will have different significance to others if the individual is female or African American rather than a white male; it may be perceived as an exceptional accomplishment, as a threat, as an aberration. Similarly, becoming an auto mechanic would be seen differently if the person is the son of an upper class white family rather than of a working class family; it may be perceived as a shame, as an act of rebellion, as a failure. Power, the ability to influence and direct the social environment in which we live, often derives from the shared power of the groups with which we are identified. Without the collective power of the group's recognized authority and influence, we become isolated and vulnerable.

These forces clearly affect the therapy process as well, as both therapists and clients view each other through the social lenses of roles and status. While this social context cannot be escaped, it can be made visible, and challenged when necessary. Awareness of the way social position has shaped the experiences of both the therapist and the client is important if both are going to fully understand the client's experience. Unrecognized differences between therapist and client in the way events are interpreted can lead to misunderstanding and the inability to build a working relationship.

For survivors in therapy this can mean the reinforcement of emotional isolation, shame, and negative images of the self. It can be experienced as a re-enactment of the invisibility and silence that have been so destructive in the past. When therapists are unaware of or deny the effects of their own social power and privilege relative to their clients, the therapists actually make it difficult to cooperatively construct a therapy environment in which clients can experience their own power and value. At worst this lack of awareness can lead to an abuse of power (either intentional or not) which further victimizes survivors and confirms rather than changes their experiences and beliefs.

There are many different types of social roles which are relevant to therapeutic work with survivors (as well as with other clients). Gender roles are clearly of central importance, since these have such significant implications for both personal experience and for social power. Gender roles are particularly important in the dynamics of domestic violence (including all kinds of abuse which occur in the context of personal relationships) since gender is an organizing concept in the structure of the family and intimate relationships of

all types. Thus, the experience of victimization will be different for men and women, and will also be affected by the gender of the perpetrator. Male against female abuse is so common and familiar, and so supported by social norms which make "normal femininity" almost equivalent to the role of a victim, that the victimization of women becomes invisible and hard to recognize.

Cultural and ethnic differences also affect the way abuse is experienced, and therefore the effects it will have on the individual. There is great variation in the norms governing what behavior is socially acceptable, how violations of acceptable behavior should be handled within the group, and when and how such violations should be revealed to "outsiders." Abuse will also be experienced very differently when it occurs within a group (when the survivor sees the perpetrator as a member of the same cultural community) and when the perpetrator is perceived as an "outsider." When group ties form the basis for a strong identification with the perpetrator, the confusion, sense of betrayal, and difficulty with anger and assigning responsibility can be reinforced (as when abuse occurs within a family). When the abuse occurs across socially defined groups differing in status and power, these social differences can increase the sense of threat, powerlessness, and inadequacy that are created by the victimization. Therapists need to be aware of these larger social issues and help their clients become aware of them as well if the survivors are to become effectively empowered to identify and challenge all aspects of the abuse.

- **Start with yourself; increase your own awareness of how your background and social position affect your thinking and behavior.** Do not make the mistake of thinking only your clients' lives require examination, and use every confusion and miscommunication that occurs in therapy to increase your awareness of the unconscious assumptions you carry. This will make it easier for you to recognize the influence of culture on your clients, and not mislabel these differences between you as evidence of pathology.

- **It is your responsibility to be informed about social differences.** If you are going to be working with someone who comes from a different social background, learn all you can about the experiences you do not share. If there is a social gap between you, it will require both of you to work to build a bridge; don't make your client do all the work. Remember, survivors have already had to do too much adapting to a social world in which their experiences are invisible or discounted.

- **Understand that social structure is complicated and that each individual has connections to many groups.** Inner-city Jewish experience is not the same as suburban Jewish experience, but individuals from both settings will have things in common not shared by their inner-city and suburban neighbors from other ethnic

groups. Class, gender, geographical location, education - these and other factors will affect experience within a cultural group, just as cultural background will affect the meaning of gender, class, and so on.

- **Remember you cannot completely rise above or eliminate the effects of social status and power in the therapy relationship.** For instance, a male therapist cannot erase his social status and power, and the meaning this would have for a female client, no matter how much he would like to have equality. By acknowledging this social reality, however, he can validate the client's perceptions and create a climate in which the client can be empowered to challenge these social roles. In this environment, they can together find mutual respect and power based on their ability to create common ground.

- **Know your limits when dealing with social differences between yourself and your client.** Especially for clients who are survivors, differences between you such as gender can be powerful triggers for emotions associated with abuse. If these reactions are too strong and cannot be balanced out early in therapy by other factors which foster a sense of safety, they can overwhelm the best efforts to establish a working relationship. This is when a referral to a different therapist is appropriate. It does not mean that you have failed as a therapist, only that you cannot be all things to all people.

Some clients with whom we work are particularly vulnerable at least in part because of their identification with social groups which have little or no status and power within this society. Awareness of these areas of vulnerability is important in working with survivors who have already been injured by abuse of power.

- **Previous history of involvement with the mental health system.** Individuals who have been labeled as mentally ill often have difficulty being heard and believed when reporting abuse or victimization. Once their credibility has been questioned, their descriptions of their experience are often explained as symptoms of their illness. Also, these individuals are often perceived as socially marginal and without powerful advocates or defenders, and therefore may be seen by perpetrators as safe targets for victimization. Thus, current or previous mental health problems may increase a person's chances of being abused and reduce their ability to deal effectively with abuse when it has occurred. While the cognitive and emotional disturbances that characterize mental illness certainly distort perceptions and experience (for instance, in psychotic conditions), we cannot automatically assume that accounts of abuse are unfounded. It is our responsibility to listen carefully to our clients, perhaps even more so when their ability to comprehend their environment is compromised in some way.

- **Substance abuse and dependence.** Many of the same concerns apply to individuals

who are struggling or have struggled with addiction. Their credibility is often in question, and they are also often marginalized. For these reasons they may be easy targets for abuse and less able to defend themselves. In addition, social attitudes toward substance abuse are still quite punitive, and these survivors are often seen as responsible for abuse that occurs when they are intoxicated. They are often perceived as undeserving of sympathy, or less seriously affected by abuse than more "innocent" victims. Conversely, perpetrators (particularly male) often are "excused" for their behavior because they were "under the influence."

- **Dependence on others for protection.** Those groups of people who are dependent on others for basic physical and social needs are also more vulnerable to victimization and less able to seek help on their own. These vulnerable groups include both the young and the old, for whom social stereotypes also involve diminished credibility. Financial dependence often restricts the ability to stop abuse by those on whom the survivor is dependent (as in much domestic violence). It also restricts a survivor's access to basics needed for healing: safety (such as a safe place to live), legal protection, medical services, and certainly mental health services. Others who are vulnerable at least in part because of their dependence on others are those with physical and mental conditions which limit their ability to function independently. When the social and physical environment presents obstacles to even day to day living for these individuals, victimization and abuse can be overwhelming.

- **Socially powerless and stigmatized groups.** In order to address issues of victimization, someone else has to be willing to listen and care. There is little of this interest and caring on the part of those with power for some groups of people; abuse and hardship may be seen as normal and even acceptable for these less powerful groups. This is especially true for the poor and near poor. Also, in order for someone to speak out about abuse, it has to be safe to be seen and heard. For stigmatized groups this is often not the case. Their safety in this society may depend on being invisible, and seeking help may involve being identified and further victimized by those who should be providing help. This is often the reality of day to day life for lesbians and gay men, for whom harassment and abuse are often socially tolerated or even encouraged.

Often vulnerability to abuse is confused with responsibility for abuse. It is important as therapists to be clear that it is not the nature of the victim that defines abuse, but the nature of the perpetrator's behavior. We do not determine whether a behavior is abusive based on how hard or easy it was for the perpetrator to commit. Being less protected, or less able to defend oneself, is not the same as inviting abuse. This is a distinction that is important to help survivors make.

Clinical Perspective: Thinking Beyond the Office

Sometimes therapists have difficulty addressing issues of vulnerability with their clients because the therapists do not want to imply any victim blaming. While vulnerability is never a cause of abuse, vulnerability to abuse is still a serious issue and needs to be addressed. Feeling better able to protect themselves is an important goal for most survivors, and recognizing areas of vulnerability is one step toward that goal.

In some cases there is little that survivors can do to eliminate a particular area of vulnerability. In this case, empowerment can mean developing the resources the survivors do have, finding other sources of strength both within themselves and within their communities. Acknowledging limitations and vulnerabilities should not be the same as helplessness or resignation to continuing victimization.

In other cases there are things survivors can do to reduce their vulnerability to abuse. Survivors can become more aware of their right to say no. They can address problems related to alcohol abuse. They can leave abusive relationships. These personal changes are often difficult, in part because past abuse reduces survivors' self-confidence. However, making a commitment to change can be an important way for survivors to reclaim their power, and limit the continuing effects of the abuse.

Systemic Obstacles to Effective Therapy with Survivors

Many of the factors which affect the work we do as therapists operate within a much broader framework than the therapy relationship, or even the sum total of the relationships in our clients' lives. Social and economic forces shape what resources are available, who will have access to these resources, and under what conditions. Currently there is little consensus in our society about the appropriate social response to the needs of survivors, and even about the nature and extent of the problem of victimization. Much progress has been made increasing awareness of the extent of violence and abuse and of the consequences of abuse for both the individual victim and the society as a whole. However, a predictable but still frightening backlash has developed in response to this progress.

The Backlash

In its broadest form, the voices of the backlash object to the focus on victimization. They argue that identifying the frequency of abuse and addressing its long term effects encourage the development of a nation of "victims" who are paralyzed by self-pity and ready to blame others for their current difficulties. To the extent that the problems of abuse and violence are addressed at all within the backlash, they are seen as relatively minor, abnormal events or as the behavior of an isolated criminal element rather than as a part of the fabric of American life. Victims are encouraged to "leave the past behind them" and not expect any "special treatment" because of the abuse. Often the focus is shifted away from the survivors' experiences and on to the effects on other people when survivors speak out. For example, the disruption of family ties becomes more significant than the abuse that occurred within that family, or the price the survivor has to pay to maintain those ties.

The message of the backlash has a powerful effect on both survivors and the therapists who work with them. It leaves survivors doubting their emotions and perceptions, sometimes even the reality of their experiences. The backlash defines survivors as the problem, reinforcing the messages of their victimization. It fosters a minimizing of the effects of abuse, making it difficult for survivors to effectively address them. And it encourages survivors to automatically put their own needs second to those of others, including the needs of others to be shielded from the truth.

The voices of the backlash have become powerful and organized, often making survivors feel even more unsafe and afraid to speak out or seek help. Survivors are afraid they will not be believed, that they will be perceived as bad. These powerful voices also lead survivors to be afraid of the very people who offer help. Therapists and others who provide

services to victims and survivors are publicly blamed for creating the problem, rather than simply exposing it. The messenger is attacked because the message is unacceptable.

The effects of the backlash are seen clearly in the "memory debate," in which the validity of survivors' memories of abuse is questioned, especially if the memories emerge after a period of being unaware. (See "Honoring the Truth: A Response to the Backlash" in Bass & Davis, *The Courage to Heal*, 3rd ed., for an excellent review of this issue.) Survivors are accused of manufacturing these memories for attention or other secondary gains, and their therapists are accused of encouraging this to keep clients dependent and to increase their profits. (It is interesting that the validity of the memory of those accused of abuse is not subject to the same scrutiny even though they clearly have a much more obvious self-serving motive for distorting their memories of events.)

The debate has often oversimplified the understanding we do have of memory and the way it works, especially in cases of trauma. (This oversimplification is apparent in the frequently quoted work of Elizabeth Loftus, and is critiqued by those who have the most extensive understanding of the effects of trauma on memory, such as Judith Herman, John Briere, Christine Courtois, Bessel Van Der Kolk and David Calof). Therapists must have an understanding of these issues if they are going to work with survivors, because survivors' experiences and memories are often fragmented and confused. There **have** been therapists who have interpreted their clients' symptoms and feelings as proof of abuse, substituting the therapists' beliefs and expectations for the clients' experience. To recognize that a client's feelings and behavior are consistent with a history of abuse (and to explore these reactions with the client) is an appropriate use of our professional knowledge. To pronounce that we as therapists know what happened, especially when our clients do not, is inappropriate.

Therapists are often the target of the backlash's anger and fear. Groups such as the False Memory Syndrome Foundation actively support family members accused of abuse in lawsuits against survivors' therapists. They publicly target therapists who specialize in work with trauma-related issues, and have developed an extensive media campaign to promote their views. In this climate it is easy for therapists to feel vulnerable and under attack, and to react defensively. We can feel afraid to trust our clinical judgment, or to intervene in ways that we know would be helpful to our clients. Or we may become so angry that we reduce the whole issue to a black and white, us versus them siege. The best protection against either of these defensive reactions is a strong connection to other service providers who are committed to self-examination and professional growth but are also willing to challenge the attacks from the backlash directly and publicly.

The Lack of Services and Resources

Although the number and types of services available to survivors has increased dramatically since these issues began to get more public attention, resources are still very far from adequate. As economic pressures have increased in society as a whole, and the social climate has changed, the resources that have been available have decreased or come under attack. The general economic decline also leads to decreases in the numbers of survivors who are able to afford services. Unfortunately, mental health services in general, and services for survivors in particular, are often seen as social "luxury items" which can be cut out without too much effect when money gets tight. In this climate, the services themselves become undervalued, and the providers are seen as less deserving of compensation. Therapists and service providers are caught in the middle, feeling overwhelmed by the needs they are trying to meet and receiving less and less in the way of financial and social support.

Unfortunately, providers who meet different but equally important needs of survivors are often in competition with each other for limited economic resources. This can lead an agency or group of providers to see others as threats to both its ability to provide services and to its ability to sustain itself and its employees. When agencies or groups become self-protective in this way and begin to protect their turf, services become fragmented and survivors suffer as well as providers. When resources are limited it becomes even more important to develop cooperative relationships among different providers. This allows for more efficiency in providing services, and less waste of resources, effectively strengthening each member. Gaps in services can also be more easily identified and addressed. Cooperation allows providers to present a stronger, more united challenge to those who question the value of this work, or who would like to maintain their denial of the need for it.

Caring for Ourselves and Each Other

Psychotherapy with survivors of abuse and trauma is difficult work, for both the therapist and the client. Not only is the work of therapy draining, but the constant exposure to the pain and fear that result from trauma can be traumatizing itself. Therapists need to know that the energy, motivation, creativity, caring, even hopefulness they need are not self-sustaining. We must be nurtured in our lives outside the office, because our clients cannot and should not be expected to keep us going. Therapists' perceptions, beliefs, and interactions become cynical and distorted, or just drained of emotional vitality, when their lives become dominated by the reality of violence and abuse of power. The experience of

pain needs to be balanced by the equally powerful realities of joy, intimacy, love, fun, hope, accomplishment.

It is easy for therapists who are committed to their work to become overwhelmed by the immense need they see. The reactions we have to our inability to meet all those needs vary among therapists, and from one time to another for each therapist. We feel frustration, self-doubt, helplessness, fear that the whole world is being overwhelmed with violence and pain. We may find ourselves shutting down emotionally to protect ourselves from these painful feelings, and thus become detached both from our clients and from our families and friends. We may find ourselves having difficulty responding fully to the real hurts and needs of family, friends, and ourselves when they seem so "minor" compared to the horror of our clients' lives. We may feel angry with clients for frustrating our need to feel effective, competent, in control - our need to feel we can change things. We may try to resolve our own histories of trauma through our clients, and thus not experience our own healing. We may become overwhelmed by despair when our best efforts cannot stem the tide of violence and abuse.

These reactions can be countered most effectively in the context of strong connections to our communities. Professional communities can provide a sense of shared experience, as well as an understanding of our frustrations and accomplishments. With others we can feel visible ourselves, and the realities of our clients' lives can also be visible and taken seriously. We are less likely to feel that change depends on us as individuals. And we can also work for change at the societal level, feeling less restricted to our individual worlds. These communities can provide a powerful antidote to the poisonous message of abuse - the message that no one hears you or sees you, no one cares. However, we may need to look for these communities and put some energy into staying connected to them. Unfortunately professional groups are as susceptible to the denial of painful truths as society as a whole. Groups which consist of coalitions across disciplines may be more likely to overcome the nearsightedness and restricted experiences which hamper some professional groups.

Relationships with supervisors or consultation groups can be a good way of addressing the links between our personal histories and our professional work. These relationships require trust and mutual respect in order to feel safe and supportive rather than shaming and judgmental. The reality of work within many organizations and agencies is that good supervision and other support for staff is either undervalued or unavailable. We may need to seek it outside the work setting.

Our personal communities of family and friends are also critical. Within these we feel valued and valuable. We can experience the hopefulness of growth. We can reconnect with the reasons why healing is important and worth the effort. We need to treat our personal lives

as valuable and worthy of protection, not just as something we do when we're not working. Our personal lives should not always be expected to step aside for our work (for meetings, phone calls, appointments, and so on). This requires a balancing act, since our work and our personal lives are not often nicely coordinated. Colleagues who are also friends can help us with frequent reevaluations of this balance. It isn't just enough to have family and friends; we have to live fully among them.

- **Remember you're not alone.** You are part of an important process that extends over time, and encompasses many people. What you do is important because it is part of this process. You can't do it alone, so don't expect yourself to try. But don't undervalue the contribution you do make. Without you the process of change would be weaker and slower.

Bass, E. and Davis, L., *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse (3rd edition),* Harper & Row, 1994.

Blumenfeld, W. J. (Ed.), *Homophobia: How We All Pay the Price,* Beacon Press, 1992.

Bolton, F., Morris, L., and MacEachron, A., *Males at Risk: The Other Side of Child Sexual Abuse,* Sage Publications, 1989.

Briere, J., *Therapy for Adults Molested as Children: Beyond Survival,* Springer, 1989.

Briere, J., *Child Abuse Trauma: Theory and Treatment of the Lasting Effects,* Sage, 1992.

Brown, L. S. and Ballou, M. (Eds.), *Personality and Psychopathology: Feminist Reappraisals,* Guilford, 1992.

Calof, D., "Facing the truth about false memory," *The Family Therapy Networker,* 17(5), September/October, 1993.

Courtois, C., *Healing the Incest Wound: Adult Survivors in Therapy,* W. W. Norton, 1988.

Chrisler, J. C. and Howard, D. (Eds.), *New Directions in Feminist Psychology,* Springer, 1992.

Herman, J. L., *Trauma and Recovery,* Basic Books, 1992.

Herman, Judith L. and Harvey M R., "The false memory debate: Social science or Social Backlash?," *The Harvard Mental Health Letter*, 9(10), April, 1993.

Lew, M., *Victims No Longer: Men Recovering from Incest,* Harper & Row, 1988.

Lobel, K., *Naming the Violence: Speaking Out About Lesbian Battering,* The Seal Press, 1986.

Mirkin, M. P. (Ed.), *Women In Context: Toward a Feminist Reconstruction of Psychotherapy,* Guilford Press, 1994.

Pearlman, L. A. and Saakvitne, K. W., *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors,* W. W. Norton, 1995.

written for this manual by Mary Margaret Hart, Licensed Psychologist

RESOURCES

Refusal to learn is more deeply a refusal to do.
Abraham Maslow

Outline for Interagency Agreement

In order to facilitate the active interagency coordination of services for victims it is suggested that interagency agreements be developed between the service providers to these individuals. It is recommended that the agreement be reviewed by each center's legal personnel.

Interagency Agreement Format:

Introduction

- to provide a statement of parties participating in the agreement
- to provide a statement of purpose for the agreement
- to provide a time duration of the agreement

General Responsibilities

- to provide a general purpose statement for each party of the agreement
- to provide a listing and definitions of all terms, phrases, words and their derivations as it pertains to the agreement

Specific Responsibilities

- to provide an explanation of the specific responsibilities and commitments made by the parties of the agreement (i.e., addressing areas of confidentiality, notice and enforcement)
  Example: Under the terms of this agreement PARTY X will be prepared:
- to maintain the individual's confidentiality

Enforcement

- to provide the specific explanation of guidelines for adherence to the agreement which includes any personnel disciplinary action by each party of the agreement

Duration

- to provide guidelines (e.g., time specifications, notice) for the duration, review and cancellation of the agreement

Signature

- to provide the necessary signatures by designated parties

Interagency Agreement Example

Agreement of Cooperation Between the Party A (Victim Services Center) and Party B (Mental Health Provider)

Introduction
This agreement between PARTY A and PARTY B will provide a referral procedure primarily to provide support to individuals who become victims of sexual assault while residing or participating in program at PARTY B. This agreement will be in effect for one year or until such time as a new agreement may be warranted.

General Responsibilities
PARTY A is a non-profit corporation chartered to provide support to victims of crime including but not limited to victims of rape, incest, child abuse and indecent assault. PARTY A is available to provide services twenty-four (24) hours a day to meet the needs of victims. PARTY B is a residential, private licensed center offering X service for persons with mental retardation.

Definitions
For the purpose of this agreement, the following terms, phrases, words and their derivations shall have meaning as follows:

A. Referral procedure: the process used to contact PARTY A
B. Support: support offered by PARTY A which can include counseling and court preparation and any other services necessary to assist the victim
C. Victim: an individual who was injured as a result of a sexual crime
D. Sexual assault: this includes crimes against the person such as rape, incest, child abuse/molestation, indecent assault, sexual harassment
E. Individual habilitation plan: a component of the life management plan as described in Chapter 4210 that is developed for a person on the basis of assessment data which specifies program interventions to attain a specific goal or objective

Specific Responsibilities
Under the terms of this agreement PARTY A will be prepared:

A. to maintain the victim's confidentiality
B. to treat the victim with dignity and respect
C. to respond twenty-four hours a day to the needs of the victim while participating with PARTY B
D. to advocate with and for the victim
E. to meet the victim at the hospital
F. to provide police and court accompaniment and court orientation
G. to provide crisis intervention, counseling and follow-up, information and referrals on terms requested by the victim
H. to obtain all necessary written releases from the victim before the case discussion with

designated persons and/or agencies

Under the terms of this agreement PARTY B will be prepared:

A. to maintain the victim's confidentiality
B. to treat the victim with dignity and respect
C. to be non-judgmental
D. to provide as part of the individual's orientation to PARTY B program information about PARTY A's services
E. to provide the victim with written notification of available services from PARTY A and an explanation of her/his rights
F. to provide a private area for the victim to make any confidential contacts with PARTY A (i.e., telephone and/or counseling contacts)

Under the terms of this agreement PARTY B will be prepared:

A. to provide any assistance per the victim's request in contacting PARTY A (e.g., availability of TDD; qualified sign language interpreter; other)
B. to provide for ambulance transport in case of medical emergency

Enforcement

If for any reason this agreement is not adhered to by the designated parties, each party will follow the terms of this agreement and their respective personnel policies regarding warranted disciplinary action.

Duration

This agreement shall be effective immediately and shall remain in effect until terminated upon thirty (30) days written notice by one or all parties involved. It shall be reviewed at least annually and may be amended at any time by the mutual agreement of the participating parties. Amendments must be written and approved by each party and attached to the agreement.

Signatures

PARTY A	PARTY B
_____	_____
Signature of Executive Director	Signature of Director
_____	_____
Type/print name above	Type/print name above
_____	_____
Date	Date

Resources

Bibliography

Crisis Intervention

Aguilera, D.C. and Messick, J.M., *Crisis Intervention: Theory and Methodology,* C.V. Mosby, 1974.

Bard, M. and Sangrey, D., *The Crime Victim's Book,* 2nd Edition, Brunner/Mazel 1986.

Edwards, R.V., *Crisis Intervention and How It Works,* Charles C. Thomas, 2nd Printing, 1979.

Figley, C. (Ed.), *Trauma and Its Wake*, Brunner/Mazel, 1985.

Gist., R. and Lubin, B. (Eds.), *Psychological Aspects of Disaster,* Wiley & Son, 1989.

Harris, C. J., "A Family Crisis-Intervention Model for the Treatment of Post-Traumatic Stress Reaction," *Journal of Traumatic Stress,* 4(2), April, 1991.

Manton, M. and Talbot, A., "Crisis Intervention After an Armed Hold-Up: Guidelines for Counselors," *Journal of Traumatic Stress,* 3(4), October, 1990.

Roberts, A. R. (Ed.), *Contemporary Perspectives on Crisis Intervention and Prevention,* Sage Publications, Inc., 1990.

Tedeschi, R. G. and Calhoun, L. G., *Crisis Intervention and Time-Limited Cognitive Treatment,* Sage Publications, Inc., 1995.

Young, M. A., *Victim Assistance: Frontiers and Fundamentals,* National Organization of Victim Assistance, 1993.

Cultural Issues

Bachman, R., *Bureau of Justice Statistics Special Report: Elderly Victims,* October 1992.

Baladerian, N. J., *Interviewing Skills to Use with Abuse Victims Who Have Developmental Disabilities*, NARCEA, 1992.

Bastian, L. D., *Bureau of Justice Statistics Report: Hispanic Victims,* January 1990.

Resources

Blumenfeld, W. J. (Ed.), *Homophobia: How We All Pay the Price,* Beacon Press, 1992.

Comstock, G. D., *Violence Against Lesbians and Gay Men,* Columbia University Press, 1991.

Essed, E., *Understanding Everyday Racism,* Sage Publications, Inc., 1991.

Fontes, L. A., *Sexual Abuse in Nine North American Cultures: Treatment and Prevention,* Sage Publications, Inc., 1995.

Griffin, L. W. and Williams, J. W., "Abuse Among African-American Elderly," *Journal of Family Violence,* 7(1), 1992.

Hamilton, J. A., "Emotional Consequences of Victimization and Discrimination in 'Special Populations of Women," *Women's Disorders,* 12(1), 1989.

Herek, G. M. and Berrill, K. T., *Hate Crimes: Confronting Violence Against Lesbians and Gay Men,* Sage Publications, Inc., 1992.

Levinson, D., *Family Violence in Cross-Cultural Perspective,* Sage Publications, Inc., 1989.

Ogawa, B., *Color of Justice: Culturally Sensitive Treatment of Minority Crime Victims,* Sacramento: Office of the Governor, State of California, 1990.

Ohio Coalition On Sexual Assault, *Guidelines for Providing Culturally Appropriate Crisis Intervention,*OCSA, 1991.

Paniagua, F. A., *Assessing and Treating Culturally Diverse Clients,* Sage Publications, Inc., 1994.

Pharr, S., *Homophobia: A Weapon of Sexism*, Chardon Press, 1988.

Ponterotto, J. G., and Pedersen, P. B., *Preventing Prejudice: A Guide for Counselors and Educators,* Sage Publications, Inc. 1993.

Ridley, C. R., *Overcoming Unintentional Racism in Counseling and Therapy,* Sage Publications, Inc., 1994.

Sobsey, R., *Violence and Abuse in the Lives of People with Disabilities*, Brooks Publishing Co.

Whitaker, C. J., *Bureau of Justice Statistics Report: Black Victims,* April 1990.

Resources

Domestic Violence

Andrews, B. and Brewin, C. R., "Attributions of Blame for Marital Violence: A Study of Antecedents and Consequences," *Journal of Marriage and the Family*, 1990.

Bachman, R., *Violence Against Women: A National Crime Victimization Survey Report*, U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, January 1994.

Block, C. R. & Block, R. L., *Questions and Answers in Lethal and Non-Lethal Violence,* National Institute of Justice, June 1992.

Browne, A., *When Battered Women Kill,* The Free Press, 1987.

Browne, A. & Williams, K. R., *Trends in Partner Homicide; A Comparison of Homicide Between Marital and Non-Marital Partners from 1976-1987,* MacMillan, 1992.

Buel, S., Groisser, S. & Marryman, M., *Harvard Law School Battered Women's Advocacy Project Training and Resource Manual,* September 1991.

Bureau of Justice Statistics, *Female Victims of Crime, 1991,* U.S. Department of Justice, 1991.

Bureau of Justice Statistics, *Report to the Nation on Crime and Justice: The Data*, U.S. Department of Justice, 1993.

Buzawa, E. S. & Buzawa, C. G., *Domestic Violence: The Criminal Justice Response,* Sage Publications, Inc., 1990.

Chesler, P., *Mothers on Trial: The Battle for Children and Custody,* Harcourt Brace Jovanovich, 1991.

Dobash, R., Dobash, R. E., Wilson, M. & Daly, M., "The Myth of Sexual Symmetry in Marital Violence," *Social Problems,* 39(1), February, 1992.

Faludi, S., *Backlash, The Undeclared War Against American Women,* Crown Publishers, 1991.

Feld, L. S. and Straus, M., "Escalation and Desistance of Wife Assault in Marriage," *Criminology*, 1989.

Ferrato, D., *Living With The Enemy,* Aperture, 1991.

Finkelhor, D., Gelles, R. J., Hotaling, G. T. & Straus, M. A. (Eds.), *The Dark Side of Families:*

Resources

Current Family Violence Research, Sage Publications, Inc., 1983.

Finkelhor, D., Hotaling, G. & Sedlak, A., *Missing, Abducted, Runaway and Thrownaway Children in America, First Report: Numbers and Characteristics, National Incidence Studies,* U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, 1990.

Gondolf, E. W. & Fisher, E. R., *Battered Women as Survivors: An Alternative to Treating Learned Helplessness,* Lexington Books, 1988.

Greif, G. & Hegar, R., *When Parents Kidnap,* The Free Press, 1992.

Hart, B., "Children of Domestic Violence: Risks and Remedies," *Courts and Communities: Confronting Violence in the Family*, National Council of Juvenile and Family Court Judges, March 1993.

Hart, B., *Violent No More,* Pennsylvania Coalition Against Domestic Violence, 1990.

Hoff, L. A., *Battered Women as Survivors,* Routledge, 1990.

Jones, A. & Schechter, S., *When Love Goes Wrong: What to Do When You Can't Do Anything Right,* Harper Collins, 1992.

Levy, B. (Ed.), *Dating Violence: Young Women in Danger,* The Seal Press,

Lobel, K., *Naming the Violence: Speaking Out About Lesbian Battering,* The Seal Press, 1986.

National Coalition Against Domestic Violence, "Facts on Domestic Violence," 1993.

NiCarthy, G., *Getting Free,* The Seal Press, 1987.

NiCarthy, G., *The Ones Who Got Away,* The Seal Press, 1990.

Radford, J. & Russell, D. H. E. (Eds.), *Femicide: The Politics of Woman Killing,* Twayne Publishers, 1992.

Steinman, M., (Ed.), *Woman Battering: Policy Responses,* Anderson Publishing Co., and Academy of Criminal Justice Sciences, 1991.

Yllo, K. & Bogard, M. (Eds.), *Feminist Perspectives on Wife Abuse*, Sage Publications, Inc., 1988.

Zorza, J., "The Cause of Half the Homelessness," *Clearinghouse Review,* 1991.

Sexual Assault

Abbey, A., "Acquaintance Rape and Alcohol Consumption on College Campuses," *Connections,* January 1993.

Allison, J. A. and Wrightsman, L. S., *Rape: The Misunderstood Crime,* Sage Publications, Inc., 1993.

Bass, E. and Davis, L., *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse,* Harper & Row, Publishers, 1988.

Bolton, F., Morris, L., and MacEachron, A., *Males at Risk: The Other Side of Child Sexual Abuse,* Sage Publications, Inc., 1989.

Briere, J., *Child Abuse Trauma: Theory and Treatment of the Lasting Effects,* Sage Publications, Inc., 1992.

Brownmiller, S., *Against Our Will: Men Women and Rape,* Sage Publications, Inc., 1984.

Calof, D. L., "From Traumatic Dissociation to Repression: Historical Origins of the 'False Memory Syndrome' Hypothesis," *Treating Abuse Today,* 4(4), July/August, 1994.

Children's Defense Fund, *The State of America's Children,* Children's Defense Fund, 1992.

Courtois, C., *Healing the Incest Wound: Adult Survivors in Therapy,* W. W. Norton, 1988.

Fairstein, L., *Sexual Violence: Our War Against Rape,* William Morrow and Company, Inc., 1993.

Faller, K. C., "Can Therapy Induce False Allegations of Sexual Abuse?", *The APSAC Advisor,* Summer 1992.

Faller, K. C., *Understanding Child Sexual Maltreatment,* Sage Publications, Inc., 1990.

Finkelhor, D. and Williams, L. M., *Nursery Crimes,* Sage Publications, Inc., 1988.

Resources

Fitzgerald, L. F., "Sexual Violence," *American Psychologist,* October 1993.

Fredrickson, R., *Repressed Memories,* Simon and Schuster, 1992.

Gonsiorek, J. C., Brea, W. H. and LeTourneau, D., *Male Sexual Abuse*, Sage Publications, Inc., 1994.

Harlow, C. W., *Female Victims of Violent Crime,* Bureau of Justice Statistics, 1991.

Hillman, D. and Solek-Tefft, J., *Spiders and Flies,* Lexington Books, 1988.

Horton, A. L., Johnson, B. L., Roundy, L. M. & Williams, D., *The Incest Perpetrator,* Sage Publications, Inc., 1990.

Hunter, M. (Ed.), *The Sexually Abused Male,* Vol. 1 & 2, Lexington Books, 1990.

Koss, M., "Rape on Campus: Facts and Measures," *Planning for Higher Education,* Spring 1992.

Koss, M. P. and Harvey, M. R., *The Rape Victim,* Sage Publications, Inc., 1991.

Lew, M., *Victims No Longer: Men Recovering from Incest,* Harper & Row, 1988.

Margolin, L., "In Their Parents' Absence," *Violence Update,* May 1993.

Muram, D., Miller, K. & Cutler, A., "Sexual Assault of the Elderly Victim," *Journal of Interpersonal Violence,* 7(1), March 1992.

National Center for Prosecution of Child Abuse, "False Memory Syndrome Foundation," *Update,* July 1992.

National Victim Center, "Male Rape," *NVC INFOLINK,* 1992.

National Victim Center, *Rape In America: A Report to the Nation,* NVC, 1992.

Peterson, A., "Sibling Sexual Abuse: The Emerging Awareness of an Ignored Childhood Trauma," *Moving Forward,* May/June 1992.

Resick, P. A., "The Psychological Impact of Rape", *Journal of Interpersonal Violence,* June 1993.

Russell, D., *The Politics of Rape: The Victims' Perspective,* Stein & Day, 1975.

Rutter, P., *Sex in the Forbidden Zone,* Jeremy P. Tarcher, Inc., 1989.

Salter, A., *Transforming Trauma: A Guide to Understanding and Treating Adult Survivors of Child Sexual Abuse,* Sage Publications, Inc., 1995.

Schudson, C. B., "Antagonistic Parents in Family Courts: False Allegations or False Assumptions of Child Sexual Assault," *Journal of Child Sexual Abuse,* 1, 1992.

Sorensen, T. and Snow, B., "How Children Tell: The Process of Disclosure in Child Sexual Abuse," *Child Welfare,* January/February 1991.

Ullman S. E. and Knight, R. A., " Fighting Back," *Journal of Interpersonal Violence,* March 1992.

Warshaw, R., *I Never Called It Rape,* Harper & Row, 1988.

Wyatt, G. E. (Ed.), *Lasting Effects of Child Sexual Abuse,* Sage Publications, Inc., 1988.

Treatment

Briere, J., *Therapy for Adults Molested as Children: Beyond Survival,* Springer, 1989.

Brothers, D., *Falling Backwards: An Exploration of Trust and Self-Experience,* W. W. Norton & Company, 1995.

Brown, L. S. and Ballou, M. (Eds.), *Personality and Psychopathology: Feminist Reappraisals,* Guilford, 1992.

Calof, D., "Facing the Truth about False Memory," *The Family Therapy Networker,* 17(5), September/October 1993.

Chrisler, J. C. and Howard, D. (Eds.), *New Directions in Feminist Psychology,* Springer, 1992.

Craig, K. D. and Dobson, K. S., *Anxiety and Depression in Adults and Children,* Sage Publications, Inc. 1994.

Herman, J. L., *Trauma and Recovery*, Basic Books, 1992.

Herman, J. L. and Harvey M. R., "The False Memory Debate: Social Science or Social Backlash?," *The Harvard Mental Health Letter*, 9(10), April, 1993.

Higgins, G. O., *Resilient Adults: Overcoming a Cruel Past,* Jossey-Bass Publishers, 1994.

Lord, J. H., *No Time for Goodbyes: Coping with Sorrow, Anger, and Injustice After a Tragic Death,* Pathfinder Publishing, 1987.

Mirkin, M. P. (Ed.), *Women In Context: Toward a Feminist Reconstruction of Psychotherapy,* Guilford Press, 1994.

Nudel, A. R., *Starting Over: Help for Young Widows and Widowers,* Dodd, Mead & Co., 1986.

Pearlman, L. A. and Saakvitne, K. W., *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors,* W. W. Norton, 1995.

Petersen, M., *At Personal Risk: Boundary Violations in Professional-Client Relationships,* W. W. Norton & Company, 1992.

Shirar, L., *Dissociative Children: Bridging the Inner and Outer Worlds,* W. W. Norton & Company, 1996.

Tedeschi, R. G. and Calhoun, L. G., *Trauma and Transformation: Growing in the Aftermath of Suffering,* Sage Publications, Inc., 1995.

Victimization

American Psychological Association, *Violence & Youth: Psychology's Response,* Vol. 1, American Psychological Association, 1993.

Copeland, L. and Wolfe, L. R., "Violence Against Women as Bias Motivated Hate Crime," Center for Women Policy Studies, 1991.

Costanzo, M. and Oskamp, S. (Eds.), *Violence and the Law,* Sage Publications, Inc., 1994.

Elias, R., *Victims Still: The Political Manipulation of Crime Victims,* Sage Publications, Inc. 1993.

Federal Bureau of Investigation, "Crime in the United States, 1992." Washington, DC. 1994.

Resources

Hampton, R. L., Jenkins, P. & Gullota, T. P., *Preventing Violence in America,* Sage Publications, Inc., 1995.

Heide, K. M., *Why Kids Kill Parents: Child Abuse and Adolescent Homicide,* Sage Publications, Inc., 1994.

Lurigio, A. J., Skogan, W. G. & Davis, R. C., *Victims of Crime: Problems, Policies and Programs,* Sage Publications, Inc., 1990.

National Victim Center, "America Speaks Out: Citizens' Attitudes About Violence and Victimization," NVC, 1991.

National Victim Center, "Opportunities for Action: Mental Health Needs of Victims," NVC, 1989.

Neiderbach, S., *Invisible Wounds: Crime Victims Speak,* Haworth Press, 1986.

Straus, M. B., *Violence in the Lives of Adolescents,* W. W. Norton & Company, 1994.

Virginians Alligned Against Sexual Assault, *Sexual Assault Crisis Centers in the United States,* VAASA, 1995.

Resources

Resources

Many of these organizations have brochures or fact sheets which could be used as handouts for victims of trauma or crime. Many also sponsor conferences to expand skills and knowledge of the topics included in this manual.

American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005, (202) 682-6000

American Psychological Association, 750 First St. N.E., Washington, D.C. 20002-4242, (202) 336-5500

Center for Women Policy Studies, 2000 P Street, N.W., Washington, D.C. 20036, (202) 872-1770

Clearinghouse on Abuse and Neglect of the Elderly, College Resources, University of Delaware, Newark, DE 19716, (302) 831-3525

Clearinghouse on Family Violence Information, P.O. Box 1182, Washington, D.C. 20013, (703) 385-7565

Crime Victims Research And Treatment Center, Medical University of South Carolina, 171 Ashley Avenue, Charleston, SC 29425, (803) 792-2945

Families of Murder Victims, Inc., 1300 Chestnut Street, Seventh Floor, Philadelphia, PA 19107, (215) 875-6475

Human Rights Resource Center, 615 B Street, San Rafael, CA 94901, (415) 453-0404

International Association of Trauma Counselors, Inc., 1033 La Posada Dr., #220, Austin, TX 78752-3880, (512) 454-3036

MADD, 511 E. John Carpenter Frwy, # 700, Irving, TX 75062-8187, (214) 744-6233

National Aging Resource Center on Elder Abuse, c/o AWPA, 810 First Street, N.E., Washington, D.C. 20002-4267

National Association of Social Workers, 750 First St. N.E., #700, Washington, D.C. 20002-4241, (800) 638-8799

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National Coalition Against Sexual Assault, 912 N. Second St., Harrisburg, PA 17102, (717) 232-7460

National Coalition Against Domestic Violence, PO Box 18749, Denver, CO 80218-0749, (303) 839-1852

National Council on Child Abuse and Family Violence, 1155 Connecticut Ave. N.W., # 300, Washington, D.C.20036, (800) 222-2000

National Indian Justice Center, The McNear Building, #7, Suite 28, Petaluma, CA 94952, (707) 762-8113.

National Institute Against Prejudice and Violence, 31 South Green Street, Baltimore, MD 21201, (410) 328-5170

National Institute of Mental Health, Department of Health and Human Services, Park Lawn Building, Room 10C-24, 5600 Fishers Lane, Rockville, MD 20857, (301) 443-3728

National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971, (703) 684-7722

National Organization of Victim Assistance, 1757 Park Rd. N.W., Washington, D.C. 20010, (202) 232-6682

National Resource Center on Domestic Violence, 6400 Flank Dr., # 1300, Harrisburg, PA 17112, (717) 545-6400

National Victim Center, 2111 Wilson Blvd., Suite 300, Arlington, VA 22201, (703) 276-2880

Office for Victims of Crime, 633 Indiana Ave. N.W., Washington, D.C. 20531 (202) 272-6500

Spiritual Dimension in Victims Services, P.O. Box 6736, Denver, CO 80206, (303) 740-8171

Southern Poverty Law Center, P.O. Box 548, Montgomery, AL 36101, (205) 264-0286

Three Feathers Associates, 1808 Newton Drive, P.O. Box 5508, Norman, OK 73070, (405) 360-2919