When Community-Based Advocates Testify as Experts: Understanding and Explaining Trauma and its Effects

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NATIONAL CLEARINGHOUSE FOR THE DEFENSE OF BATTERED WOMEN
Working for justice for victims of battering charged with crimes

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Table of Contents

Introduction

In recent years, there have been increasing efforts by federal agencies, practitioners, funders, and others to ensure that community interventions and social services reflect a solid understanding of trauma and its many effects. As a result, numerous organizations and practitioners have developed and implemented "trauma-informed approaches" to how they implement their work. For example, in 2005, the National Center on Trauma-Informed Care opened their doors and is just one of many organizations that focus on a trauma-informed approach.

In response to this proliferation of "trauma-informed" approaches, many community-based advocates who have been working with survivors of battering and/or sexual assault (especially those who have been doing such work for a long time) have asked, "But isn't all of our work trauma-informed?" Although in the past, the term "trauma-informed" may not have been used to describe how advocates were (and are) trained to provide services or develop and implement programs, advocates' work is all about being trauma-informed. While some community-based advocates may not know or use all the "trauma-informed" nomenclature or "buzz words," they probably already have a solid, trauma-informed base of knowledge.

Advocates who testify as expert witnesses in court or in administrative hearings are sometimes called upon to explain complex concepts about trauma to jurors and others who do not have that same base of knowledge. Understanding the effects and consequences of experiencing traumatic events is difficult, and helping others understand those effects can be even more so. Trauma does not, and cannot, always explain everything about a person's behavior; however, it may help to explain some of the common, yet potentially puzzling, behaviors advocates regularly observe when working with survivors.

This document is intended for community-based advocates who work with domestic violence and/or sexual assault survivors, particularly advocates who may testify in court as expert witnesses. The goal of this resource is to help advocates understand and explain complex ideas about trauma in ways that are easily understood and accurate to jurors and others.

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Part I: Trauma and its Effects

WHAT IS TRAUMA?

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (https://www.samhsa.gov/trauma-violence).

"Traumatic stress" describes an event and its result, where 1) "the individual experiences or witnesses a threat to her own or another's life or physical integrity, and 2) in response, the individual's ability to integrate the emotional experience of the threat is overwhelmed" (adapted from the International Society for Traumatic Stress Studies, https://www.istss.org/public-resources/what-is-traumatic-stress.aspx).

WHAT KINDS OF EVENTS ARE COMMONLY CONSIDERED TRAUMATIC OR ARE "TRAUMATIC STRESSORS"?

According to the fifth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), traumatic events are ones where a person is exposed to or threatened with death, physical injury, or sexual violence; the person witnesses a threat to someone else's life or physical integrity; the person indirectly learns that a loved one was exposed to trauma (where, if the trauma involved actual or threatened death, it was violent or accidental); or the person experiences repeated or extreme indirect exposure to others' trauma, usually in the course of professional duties (e.g., first responders or therapists), although not through electronic media, television, movies, or pictures (https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-PTSD.pdf

and

http://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp).

Generally, the types of circumstances that are commonly understood to cause traumatic emotional responses include childhood abuse or neglect; physical, emotional, or sexual abuse; witnessing acts of serious violence; life-threatening accidents and/or medical interventions; natural disasters; war; the accidental or violent death of a loved one; and cultural, intergenerational, and/or historical acts of

hostility or genocide against a group of people (https://www.thenationalcouncil.org/wp-content/uploads/2013/05/Trauma-infographic.pdf).

WHAT ARE COMMON TRAUMA RESPONSES?

The National Center for PTSD (NCPTSD)[1] reports that, "After going through a trauma, survivors often say that their first feeling is relief to be alive. This may be followed by stress, fear, and anger. Trauma survivors may also find they are unable to stop thinking about what happened. Many survivors will show a high level of arousal, which causes them to react strongly to sounds and sights around them."

According to NCPTSD, common trauma responses include: feeling hopeless about the future; feeling detached or unconcerned about others; having trouble concentrating or making decisions; feeling jumpy and getting startled easily at sudden noises; feeling on guard and constantly alert; having disturbing dreams and memories or flashbacks; having work or school problems; having stomach upset or trouble eating; having trouble sleeping and feeling very tired; pounding heart, rapid breathing, feeling edgy; sweating; severe headaches if thinking of the event; failure to engage in exercise, diet, safe sex, regular health care; excess smoking, alcohol, drugs, food; having ongoing medical problems get worse; feeling nervous, helpless, fearful, sad; feeling shocked, numb, and unable to feel love or joy; avoiding people, places, and things related to the event; being irritable or having outbursts of anger; becoming easily upset or agitated; blaming oneself or having negative views of oneself or the world; distrust of others, getting into conflicts, being over-controlling; being withdrawn,

Other definitions of trauma and traumatic events:

Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. The American Psychological Association http:/www.apa.org/topics/trauma/

A traumatic event is something terrible and scary that you see, hear about, or that happens to you. During a traumatic event, you think that your life or others' lives are in danger. You may feel afraid or feel that you have no control over what is happening around you. Most people have some stress-related reactions after a traumatic event.

National Center for PTSD (http://www.ptsd.va.gov/public/PTSD-overview/basics/what-is-ptsd.asp).

[1] PTSD will be discussed below.

feeling rejected, or abandoned; and/or loss of intimacy or feeling detached (http://www.ptsd.va.gov/public/problems/common-reactions-after-trauma.asp).

IF SOMEONE HAS EXPERIENCED TRAUMA, HOW MIGHT THEY PRESENT TO OTHER PEOPLE?

It is extremely common for trauma survivors to:

- Describe parts of their story about the traumatic event differently from one telling to the next;
- Talk about events in random order, rather than chronologically;
- Display unexpected or surprising emotional responses; and/or
- Go off on "tangents" as they are speaking.

These forms of expression following a traumatic event are not only typical, but are to be expected. These behaviors are "normal" responses to abnormal events. These responses are not "crazy"; such behavior makes sense in the context of trauma.

WHAT HAPPENS TO A PERSON FOLLOWING A TRAUMATIC EVENT TO GENERATE COMMON TRAUMA RESPONSES?

Although community-based advocates are not expected to become specialists in neurobiology or how brains function, having some basic knowledge about what happens to a person physiologically following a traumatic event can be helpful to understanding trauma.

The brain processes information differently during traumatic events than during non-traumatic situations. When the brain detects a threat, it releases different hormones, which in turn cause the body to "shut down" in certain ways as a protective mechanism. This shutting down affects how and where memories of traumatic events, and the person's emotional responses to them, are stored in the brain.

As a result, memories of traumatic events are more likely to be disjointed and non-linear, and trauma survivors' verbal accounts of those events are similarly disjointed and out of sequence. In addition, after an immediate traumatic event has passed, the brain will also engage in a variety of unconscious protective mechanisms in response to the trauma, such as engaging in behaviors that allow the trauma survivor to avoid re-experiencing the traumatic event or being on "high alert" to scan the environment for possible additional harm.

WHAT IS PTSD? ARE TRAUMA AND PTSD DIFFERENT?

Posttraumatic Stress Disorder (PTSD) is an actual psychological diagnosis defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the manual used by mental health clinicians and practitioners to diagnose mental health conditions. To be diagnosed with PTSD, an individual must meet four specific criteria following a traumatic event, including (1) re-experiencing the trauma (e.g., flashbacks or nightmares), (2) avoidance behaviors (e.g., avoiding people, places, scents, etc., associated with the traumatic event), (3) heightened arousal (e.g., feeling hyper-aware of one's environment), and (4) negative beliefs and feelings (e.g., anger, fear, guilt, shame). If a person displays all four types of these responses to a traumatic event for more than four weeks following the traumatic incident, then they may fit the criteria for PTSD (https://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp).

According to the National Center for PTSD, the symptoms of PTSD usually begin soon after the traumatic event, but sometimes they do not emerge until months or years later. The effects of trauma may come and go over many years (http://www.ptsd.va.gov/public/PTSD-overview/basics/what-is-ptsd.asp and http://www.ptsd.va.gov/professional/PTSD-overview/dsm5_criteria_ptsd.asp).

Although many people are exposed to traumatic events, not everyone develops PTSD (http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp). Many people who exhibit a variety of effects of trauma meet the criteria for PTSD. If a person who experienced a traumatic event displays only some of the criteria for PTSD, then practitioners may assess that person as having "partial PTSD" (http://www.ptsd.va.gov/professional/newsletters/research-quarterly/v25n1.pdf).

A "trauma-informed approach" (addressed further below) has nothing specifically to do with whether someone has a diagnosis of PTSD or not. It is about understanding the impact of trauma and how someone might think, perceive, or behave differently as a result of trauma.

WHAT IS COMPLEX PTSD?

According to the National Center for PTSD (NCPTSD), "Complex PTSD" is a way to describe the effects of long-term, chronic exposure to traumatic events where the victim is held in a state of physical or emotional captivity, is under the control of the perpetrator, and is unable to escape. Examples of such traumatic situations include: concentration camps, prisoner of war camps, human trafficking situations, long-term domestic violence, long-term child physical abuse or child sexual abuse, or organized child exploitation rings (http://www.ptsd.va.gov/professional/PTSD-overview/complex-ptsd.asp).

Some definitions of "Complex PTSD" focus on the complicated traumatic experiences of someone who is repeatedly abused as a child (usually by a caregiver or trusted person) and then experiences multiple traumatic events as an adult (Courtois, C.A. & Ford, J. (2009). Treating complex traumatic stress disorders: An evidence-based guide. New York: Guilford Press).

"Complex PTSD" is not a separate diagnosis classification under the DSM-5 because research suggests that 92% of individuals with Complex PTSD also met the diagnostic criteria for PTSD. However, treatment for individuals who have experienced prolonged, repeated trauma may be different than treatment for others who have been exposed to one-time or short-term traumatic events (ISTSS Complex PTSD Treatment Guidelines http://www.istss.org/treating-trauma/istss-complex-ptsd-treatment-guidelines.aspx).

NCPTSD also describes additional complex trauma responses resulting from months or years of chronic victimization and total control by another, including difficulties with emotional regulation (e.g., persistent sadness, explosive anger, or inhibited anger); self-perception (e.g., helplessness, guilt, stigma, a sense of being completely different from others); distorted perceptions of the perpetrator (e.g., attributing total power to the perpetrator or becoming preoccupied with revenge); relations with others (e.g., isolation, distrust, repeated search for a rescuer); and one's system of meanings (e.g., loss of sustaining faith or a sense of hopelessness and despair) (http://www.ptsd.va.gov/professional/PTSD-overview/complex-ptsd.asp).

IS "TRAUMA" A DIAGNOSIS?

No, trauma is not a diagnosis. Trauma is the description of a traumatic event and its emotional effects.

DO TRAUMA RESPONSES VARY DEPENDING ON THE TYPE OF TRAUMATIC EVENT A PERSON EXPERIENCED?

Yes, trauma symptoms can be different based on the type of traumatic event to which the person was exposed. While there are common symptoms that many people who have been exposed to any kind of traumatic event experience (such as intrusive thoughts, feelings of helplessness, anxiety, and/or avoidance, as described above), there can be some distinctions between the kinds of traumatic symptoms that a trauma survivor displays based on the kind of trauma that person experienced. For instance, people who experience rape tend to have trauma symptoms related more to intimacy and sex than people who been exposed to other kinds of traumatic experiences.

IS TRAUMA CAUSED BY AN ISOLATED INCIDENT (SUCH AS RAPE OR A SERIOUS CAR ACCIDENT) DIFFERENT FROM TRAUMA CAUSED BY CHRONIC STRESSORS (LIKE LIVING IN A DANGEROUS NEIGHBORHOOD OR EXPERIENCING ONGOING ABUSE BY AN INTIMATE PARTNER)?

Yes, there is generally a difference between the traumatic responses to one-time exposure to a traumatic event versus a chronic or ongoing series of traumatic events. Chronic stressors tend to create more persistent or entrenched symptoms that affect more areas of trauma survivors' lives. The exception to that is rape trauma, which tends to have the highest incidence of PTSD, even when compared to men who have experienced military combat (http://www.ptsd.va.gov/professional/treatment/women/ptsd-womens-providers.asp).

For someone who experienced a traumatic event in the past, but is not currently exposed to ongoing traumatic events, many of the symptoms associated with trauma may be resolved for that person over time. However, depending on a variety of factors in the individual's life, there may also be lasting effects or seemingly "permanent" changes in how a trauma survivor responds to other life events or performs daily functions as a result of the traumatic event.

People who are still experiencing ongoing exposure to traumatic events (such as domestic violence survivors who live with their abusive partners) generally must manage their trauma responses while simultaneously engaging in strategies designed to minimize their exposure to additional harm. Community-based advocates are familiar with this phenomenon, such as when domestic violence survivors appear emotionally shut down while nevertheless maintaining an ability to assess potential sources of danger and implement strategies to reduce the likelihood of future harm. Healing from the effects of trauma is extremely difficult when people are still exposed to ongoing sources of trauma.

WHAT FACTORS MIGHT AFFECT HOW ONE RESPONDS TO OR COPES WITH A TRAUMATIC EVENT?

How someone responds to and copes with a traumatic event(s) can depend on numerous factors including: the event(s) that happened; how close the person was to what happened (e.g., whether the person was harmed directly, witnessed the event, or heard about it after the fact); whether the traumatic event is ongoing (e.g., abuse from a family member or intimate partner) or a one-time event; whether the person experienced it alone or with other people; whether the harm was created by another person, an institution, and/or was a "natural" disaster (the effects of which may be exacerbated by institutional responses, such as with Hurricane Katrina); whether the

event was the result of an intentional act or an accident; whether the traumatic event was caused by a person in a position of authority (e.g., a parent, clergy member, or police officer); how individuals and institutions respond to the survivor during and after the traumatic event (e.g., whether the trauma survivor is believed, blamed, criminalized); how much help and support the survivor received or generated for herself after the event; the survivor's prior life history, experiences, inner resources, coping styles; and many other factors (including being a part of a group that experiences systemic oppression) (adapted from http://www.ptsd.va.gov/public/PTSD-overview/basics/what-is-ptsd.asp).

IS THE TRAUMA EXPERIENCED BY SURVIVORS OF DOMESTIC AND/OR SEXUAL VIOLENCE DIFFERENT THAN TRAUMA RESULTING FROM OTHER EXPERIENCES?

Yes, the trauma experienced by survivors of domestic and/or sexual violence often results in different trauma responses compared to other trauma survivors. This is because survivors of domestic and sexual violence are often harmed by someone whom they know, and/or to whom they are close. Such betrayals of trust often intensify the impact of the trauma.

DO ALL PEOPLE WHO EXPERIENCE AN EVENT THAT IS LIKELY TO BE TRAUMATIC, SUCH AS BEING RAPED, DEVELOP TRAUMA SYMPTOMS?

No, not everyone who experiences a traumatic event will have trauma symptoms. Inherently, all people who experience a potentially traumatic event experience some sort of reaction, but not everyone will have trauma "symptoms" or develop a trauma response. In addition, most people who experience traumatic events do not develop PTSD. Even though rape survivors have the highest incidence of PTSD among trauma survivors, for example, the majority of rape survivors do not develop PTSD; research suggests about 45% of women who report having been raped developed PTSD (http://www.ptsd.va.gov/professional/treatment/women/ptsd-womens-providers.asp). Recent studies have shown that young adults are exposed to potential traumatic events six times a year. However, more than half (55 to 65%) exhibit resiliency (no or a low level of symptoms or distress), so resiliency is the most common response (Bonanno, G. (2014). Beyond Resiliency and PTSD, webinar provided by ISTSS; see, also, http://faculty.tc.columbia.edu/upload/gab38/americanPsychologist.pdf).

Imagine. . .

An analogy may be useful to help describe the different effects that the source of trauma may have on trauma survivors. Imagine standing at the precipice of a deep gorge, with only a rope bridge available to get you safely to the other side. Then, imagine the possible emotional effect of encountering different barriers to safely crossing the bridge. Consider how it would feel to look across the span of the gorge and take the first step of a trip across; you likely would experience extreme fear that would linger with you for a period of time even if you successfully cross the bridge.

Then imagine if you could see storm clouds in the distance that might bring a tropical storm before you reach the other side, but you manage to get across; you likely would experience a heightened sense of fear than if there were no storm clouds because of the greater danger posed by the impending storm. Then, imagine if the storm actually arrived and washed away the other side of the bridge as you were crossing it, leaving you hanging from the rope, suspended over the gorge; the terror you experienced would likely be more acute, and would most likely have a more lasting physical and emotional effect than if the bridge had not actually been washed out.

Next, imagine if there were a stranger on the other side of the bridge, threatening to cut the rope; even if the stranger never cut the rope, the resulting fear from an intentional threat by another person may have different lasting physical and psychological effects than the fear of harm from a natural disaster. Then, imagine if the stranger actually cut the rope, leaving you to dangle over the gorge and make your own way to safety; your ability to make sense of and recover from such an intentional and harmful act would be expected to take much longer than if there was no perceived threat to the stability of the bridge.

Then, imagine if, after you already started across the bridge, your abusive partner arrived and threatened to cut the rope; the amount of fear you would experience due to the threats of someone known to you, whom you already know is capable of harming you, might be even greater than a similar threat by a stranger. Finally, imagine if your abusive partner actually cut the rope while you were on the bridge, leaving you suspended over the gorge; the resulting betrayal you would probably feel would likely amplify the feelings of fear, and it is possible that the traumatic effects would linger much longer than in the other situations described.

Thus, although the traumatic event is the same — attempting to cross a dangerously precarious bridge — the emotional effects of the various sources of additional danger will vary in intensity and duration based on whether the risk of harm is foreseeable, is a random act of nature, is the result of an intentional act by another person, and/or is the result of an intentional act by someone whom the trauma survivor once trusted or who was in a position of trust.

WHY MIGHT PEOPLE HAVE DIFFERENT RESPONSES TO THE SAME TRAUMATIC EVENT?

The ability to manage potentially traumatic events is what is called resiliency. There is no one factor that determines resiliency or who will be able to manage potentially traumatic events without developing diagnosable symptoms. Some people may be born hard-wired to manage traumatic situations effectively; some may have a variety of resources available that support their resiliency; some may have learned to be more optimistic in the face of adversity. Resiliency is made up of many factors — both small and large — that all add up to a positive outcome. However, each only plays a role combined with many other factors that result in resiliency. There is quite simply no one major predictor, but often a lot of little things add up to create resiliency.

WHY DO SOME TRAUMA SURVIVORS DEVELOP PTSD AND OTHERS DO NOT?

We do not really know why some people develop PTSD and others do not. This goes back to the discussion about resiliency.

HOW DO TRAUMA SURVIVORS ADAPT OR DEVELOP STRATEGIES TO DEAL WITH THEIR TRAUMATIC EXPERIENCES?

Many of the strategies trauma survivors develop are dependent on whether they continue to be exposed to possible traumatic events. For domestic violence survivors, the reality is that many survivors still live in danger, either because they do not want or are unable to leave their abusive partners or because they are forced to continue to engage with abusive former partners (for example, through the family court system). When trauma survivors are still in danger, they frequently adapt by being hyper-vigilant to sources of possible harm and try various ways to stay safe, which may include safety planning with a community-based advocate through an intervention program.

When domestic violence survivors are no longer exposed in an ongoing way to harm from an abusive partner or former partner, advocates frequently use the term "the new normal." This describes survivors who have found ways to manage the effects of the prior trauma, but whose lives are clearly changed. Changed does not mean better or worse, just different. Many trauma survivors learn to adequately adapt and develop strategies to manage the effects of their prior traumatic experiences. Often times, survivors do so with the help of the domestic violence program or other supportive services.

ARE ALL THE WAYS IN WHICH A PERSON RESPONDS TO A TRAUMATIC EVENT CONSIDERED A TRAUMA RESPONSE? FOR EXAMPLE, IF A PERSON IS ROBBED AND THEN DECIDES TO CARRY PEPPER SPRAY, IS THAT EVIDENCE THAT THE PERSON EXPERIENCED TRAUMA OR HAD A TRAUMATIC RESPONSE?

No, not all life changes that occur after a traumatic event are trauma. Carrying pepper spray after being robbed is a strategy that some people may choose in order to feel more empowered to protect themselves. That choice is not considered trauma, but rather is a strategy to increase future safety. In contrast, evidence that the same person experienced trauma would include having disturbing dreams, avoiding the block where the robbery happened, being startled easily at sudden noises, and/or feeling like the world is an unsafe place.

CAN SOMEONE ALWAYS TELL IF ANOTHER PERSON IS EXPERIENCING TRAUMA? DOES ONE HAVE TO BE A PSYCHOLOGIST OR THERAPIST TO KNOW?

No, it is not always noticeable that someone is experiencing trauma. Many trauma symptoms are quite private and would not be noticed by anyone else. Even someone very close to a person who is experiencing trauma may not see the internal process related to intrusive thoughts, feelings of helplessness, anxiety, avoidance, or other responses that are common trauma responses. A therapist might be more capable of assessing how a person is responding; however, one does not have to be a therapist or psychologist to recognize some of those symptoms, depending on what they are, of course.

WHAT IS A TRAUMATIC "TRIGGER?"

Many people who do not have specific expertise in trauma use the term "trigger" to mean something that causes someone to be upset by something. However, from a psychological perspective, trauma responses are "triggered" by a sensory experience that reminds the person of some aspect of a prior traumatic event. A sight, sound, smell, taste, or mental image created by hearing facts of a similar traumatic event that happened to another person may cause a trauma survivor to re-experience a previous traumatic event. It is useful to help survivors identify when they are being triggered by something related to the trauma so they can more effectively manage their responses. The goal, however, is not necessarily to completely avoid triggers (because avoiding all triggers is beyond a person's control), but to help survivors manage their responses when they are triggered.

CAN SOMEONE EXPERIENCE TRAUMA FROM AN OCCURRENCE THAT IS NOT TRAUMATIC TO MOST PEOPLE, SUCH AS TAKING A TEST OR MISSING A PLANE?

No, a person cannot experience trauma from an event that is not traumatic. By definition, in order to experience trauma, there has to have been a traumatic event (where the person experienced, witnessed, or learned of an actual or threatened death, serious physical injury, or sexual assault). Taking a test or missing a plane does not rise to the level of a traumatic stressor. If a person has an adverse reaction to a non-traumatic event, those responses might be rooted in some other cause, including *past* trauma. In other words, if missing a plane triggers a trauma response, the underlying cause of that response is not missing the flight, but rather a previous traumatic event (such as being beaten by one's partner as punishment for missing a flight).

WHAT ARE "TRAUMA-INFORMED SERVICES"?

All advocates who have training in the areas of domestic violence or sexual assault are taught basic concepts about the effect of trauma and how to appropriately interview someone who has experienced traumatic events. Thus, advocates are trained to provide "trauma-informed" interventions, even if those words are not used to describe the work.

At their core, trauma-informed interventions recognize the presence of trauma symptoms and acknowledge the impact of trauma. For example, instead of starting an interview by asking, "What's wrong with you?" a practitioner using a trauma-informed intervention would ask, "What happened to you?" This approach engages and includes the people who are seeking assistance and uses practices that support and empower survivors. The practitioner adopts an attitude of empathy to help understand things from the perspective of the survivor. This approach minimizes the re-victimization of the survivor and facilitates the survivor's recovery and empowerment.

Advocates who work with domestic violence and sexual assault survivors are taught that trauma survivors frequently have difficulty with memory, recounting the sequence of events, and explaining how specific events unfolded. Trauma-informed interviewers ask open-ended questions and allow survivors to talk in their own timing. Survivors are allowed to "tell their story." This interviewing style is in contrast to the way a law enforcement interview is typically done. Law enforcement officers generally want the details of each incident, in the exact order in which it occurred, with no information left out. This type of interview is almost completely opposite of the way someone would conduct a trauma-informed interview.

ADVOCATES FROM THE DOMESTIC VIOLENCE AND SEXUAL ASSAULT FIELDS HAVE ALWAYS BEEN TRAINED TO BE UNDERSTANDING OF AND RESPONSIVE TO THE TRAUMA HISTORIES AND RESPONSES OF THE SURVIVORS THEY ASSIST. EVEN THOUGH IT WASN'T ALWAYS CALLED "TRAUMA-INFORMED" PRACTICE, ISN'T THAT WHAT THEY HAVE ALWAYS BEEN DOING?

Yes, most training for advocates about working with domestic violence and sexual assault survivors has been built around what we now call a "trauma-informed" model.

GIVEN THAT TRAUMATIC RESPONSES ARE SOMETIMES DESCRIBED AS "NORMAL RESPONSES TO ABNORMAL EVENTS," HOW DOES REFERRING TO TRAUMATIC RESPONSES AS "NORMAL" BENEFIT SURVIVORS AND THE PEOPLE WHO WORK WITH THEM?

"Normal" means that a person's traumatic responses to a traumatic event are typical and/or expected. Many responses to traumatic events feel pretty "crazy" to the person who is experiencing them. Letting survivors know that their responses to what happened are common responses to trauma can help them to feel more "normal" and less alone, isolated, and/or misunderstood.

IF IT IS COMMON FOR PEOPLE WHO HAVE EXPERIENCED TRAUMA TO FREQUENTLY CHANGE THEIR STORY, HOW CAN ONE TELL THE DIFFERENCE BETWEEN SOMEONE WHO IS COPING WITH TRAUMA FROM SOMEONE WHO IS LYING?

There is no foolproof way to determine if someone is lying or not. However, research has shown that there are certain expectations of trauma survivors' behavior that can help practitioners assess for trauma — people who have experienced trauma often add or omit parts of their story about the traumatic event from one retelling to another; tell things in a different order than before; have a "flat affect" (i.e., speak in a monotone, with limited facial expressions, and appear apathetic or otherwise lacking emotion) when recounting traumatic events; and they often leave out significant relevant information about what happened. When a trauma survivor does these things, it is expected.

In contrast, someone who is lying will usually be "too perfect" in presenting information about the event. It is actually a "red flag" for malingering (the term for intentionally giving false information with the goal of receiving a reward or benefit) if a person who says she experienced significant trauma tells everything in order and in great detail, keeps the same story with no variation from one telling to the next, and maintains one emotional response throughout the telling (such as being consistently tearful, in contrast to having a "flat affect").

An additional reality is that sometimes trauma survivors do lie, but doing so does not mean that they did not experience a traumatic event to which they had (or continue to have) a traumatic response. There may be multiple reasons why a particular trauma survivor deliberately gives false information, or withholds information, about one piece of the story; such reasons may be directly related to the survivor's efforts to reduce the likelihood of future harm or otherwise maintain a sense of safety. Although it is difficult, if not impossible, to know how common it is for trauma survivors to make strategic decisions to share false information or to withhold relevant information, such decisions do not erase the traumatic event nor negate the survivors' traumatic response.

IS TRAUMA ALWAYS CONSIDERED A MENTAL HEALTH CHALLENGE, MENTAL HEALTH ISSUE, CONDITION, ILLNESS, DISORDER, OR PSYCHIATRIC DISABILITY?

Yes, on the most basic level, trauma is considered a "mental health challenge," because trauma describes a situation where an individual's ability to cope with experiencing, witnessing, or learning about a traumatic event is overwhelmed in a way that negatively affects her ability to function effectively in her life. For example, prolonged sleep deprivation due to being hyper-alert or being afraid of having event-related nightmares may lead to irritability or anxiety, and may affect a trauma survivor's ability to concentrate or make decisions. Even though the trauma survivor may be exhibiting "normal" responses to an abnormal situation, such responses pose a mental health "challenge." Whether such challenges last a day, a week, a month, or years varies tremendously from person to person, depending on many factors.

However, experiencing traumatic responses to a traumatic event does not always rise to the level of a mental health issue, illness, disorder, or psychiatric disability. Because trauma survivors are only considered to have developed PTSD if they continue to experience the effects of trauma across four specific categories for more than 30 days, experiencing traumatic effects for fewer than 30 days is not considered a disorder (or a form of mental illness or psychiatric disability).

Further, given that traumatic events are so prevalent, and because the effects of trauma are so common, the DSM-5 redefines PTSD as a new category of "trauma and stressor-related disorder," replacing its earlier classification as an anxiety disorder.

In certain circumstances, experiencing a traumatic event and its effects can exacerbate a survivor's existing mental health conditions or predispositions, such as schizophrenia. In other circumstances, the trauma and its effects may contribute to the survivor developing a related mental health issue or disorder, such as bulimia nervosa (https://www.nationaleatingdisorders.org/sites/default/files/ResourceHandouts/TraumaandEatingDisorders.pdf). In either situation, the trauma and its effects will be relevant to developing effective treatment for the mental health issue.

IF TRAUMA SURVIVORS GENERALLY HAVE MENTAL HEALTH "CHALLENGES," THEN DOES THAT MEAN THEY ARE TOO IMPAIRED TO FUNCTION IN THE WORLD (E.G., RAISE THEIR CHILDREN, HOLD A JOB, TESTIFY CREDIBLY IN COURT, ETC.)?

No, it is not generally true that trauma survivors are too impaired to function in the world, even when they experience mental health challenges related to the trauma. Many trauma survivors manage quite effectively to raise their children, hold a job, testify on their own behalf in court, and otherwise function in the world, even while coping with the effects of ongoing and/or past trauma. People who have experienced trauma do not necessarily have any more difficulty raising their children than anyone else. The ability to parent or perform other daily tasks depends on the extent of the effects of the trauma and the frequency, extent, duration, and effect of traumatic responses to trauma triggers. But, most often, trauma survivors are effective parents.

Sometimes trauma survivors who function effectively in the world nevertheless have a difficult time in court providing effective testimony, however, because the material about which they are testifying is related to the trauma. In some situations, survivors may experience the effects of the trauma in the moment, which can result in the survivor having a flat affect when recounting events, for example, or telling the story in a non-linear way. While having a trauma reaction in the moment can make it difficult for judges or juries to follow or understand a survivor's testimony, expert testimony about the effects of trauma can sometimes help ensure that these difficulties do not impact a survivor's credibility.

ARE PROPONENTS OF "TRAUMA-INFORMED RESPONSES" ESSENTIALLY TRYING TO PUT PEOPLE WHO HAVE EXPERIENCED TRAUMA AND PEOPLE WHO HAVE MENTAL HEALTH CHALLENGES IN DIFFERENT CATEGORIES? IN OTHER WORDS, ARE WE SAYING THE PEOPLE WHO HAVE

EXPERIENCED TRAUMA NEED X, WHILE PEOPLE WITH OTHER MENTAL HEALTH CHALLENGES NEED Y?

Every mental health challenge is in its own category, with the possibility that various types of mental health challenges, illnesses, or disorders overlap with each other and/or with the effects of trauma.

In other words, trauma and its effects is distinct from other mental health issues, such as depression, anxiety, bipolar disorder, schizophrenia, borderline personality disorder, panic disorders, attention deficit hyperactivity disorder, eating disorders, or other mental health conditions. In addition, given how prevalent traumatic events are, people with those mental health conditions often also experience trauma, which in turn may affect how the symptoms of their mental health disorders manifest, or how they experience the effects of trauma.

It might be helpful to delineate different situations in which various mental health challenges and the effects of trauma may, or may not, overlap.

In one situation, someone may have an independent, pre-existing "diagnosable" mental health disorder or disorders (such as clinical depression, anxiety disorder, bipolar disorder, schizophrenia, borderline personality disorder, panic disorders, an eating disorder, or attention deficit hyperactivity disorder, etc.) and then experience a traumatic event. The effects of the trauma may exacerbate the person's underlying mental health issue. Effective interventions by community-based advocates, or effective treatments by mental health treatment providers, require addressing the trauma in the context of the underlying mental health issue, and vice-versa. Generally, mental health treatment providers have realized over the years that just treating the symptoms of a person's mental health condition outside the context of trauma does not result in satisfactory outcomes.

In another situation, a person may develop depression, an anxiety disorder, PTSD, other mental health issue after, and in response to, experiencing a traumatic event or events. For such survivors, various factors may contribute to them developing separate mental health condition following a traumatic experience (including genetic predispositions). Developing effective interventions or treatments for the mental health issue also requires addressing the underlying trauma.

In other situations, some people who experience a traumatic event and have a trauma response to that event do not also develop other separate mental health issues, such as depression or an anxiety disorder. Such trauma survivors experience the common effects of trauma (e.g., avoidance behaviors, hyperarousal, etc.) for a limited period of time following the traumatic event, but the effects of the trauma do not adversely affect their ability to function in the world in an ongoing way, nor lead to the development of other mental health conditions.

Finally, as discussed above, some people experience an event that could be considered traumatic (such as nearly being hit by a car), but do not experience the common traumatic responses.

In all of these situations, it is useful for advocates and other practitioners to consider whether a person's experience of a traumatic event results in traumatic responses that may or may not relate to or overlap with other mental health conditions.

IN THE PAST, DOMESTIC VIOLENCE SURVIVORS HAVE BEEN DESCRIBED AS "HELPLESS" BECAUSE OF THEIR CIRCUMSTANCES. IS SUCH A DESCRIPTION ACCURATE? AND IF NOT, WHY NOT?

The early research and writing by Dr. Lenore Walker presented battered women as experiencing "learned helplessness" in response to the traumatic events they experienced. This term is often confusing and led people to inaccurately believe that a "true battered woman" was helpless, did not fight back, and did little on her own behalf or to protect herself.

In truth, domestic violence survivors are very resourceful. They often argue, use physical force to resist their abusive partner's violence, and use other creative tools and strategies to try to change their situation, increase their options or their access to safety, and make their lives better. Domestic violence survivors engage in many behaviors as they deal with the circumstances of living with ongoing trauma. While in some instances, such behaviors and strategies may appear to outsiders as suggesting that the survivor is "passively complying" with the abuse, even such compliance strategies indicate an informed and often active consideration of what response is most likely to reduce the harm directed at the survivor, and most likely to increase the survivor's safety.

DO TRAUMA EXPERTS THINK THAT TRAUMA SURVIVORS SHOULD GET A "FREE PASS" FOR BAD BEHAVIOR? IN OTHER WORDS, SHOULD TRAUMA SURVIVORS BE TREATED DIFFERENTLY THAN OTHER PEOPLE WHO DO BAD ACTS OR ARE ON TRIAL FOR CRIMINAL CHARGES?

When trauma experts urge people to consider trauma survivors' negative behaviors in the context of trauma, experts are not making "excuses" for trauma survivors' bad behavior. Rather, trauma experts recognize that when there is a context for trauma survivors' behavior — namely, traumatic events and survivors' responses to that trauma — that context needs to be considered in order to fully understand survivors'

actions and responses. Offering an explanation is different from excusing the behavior.

Culpability tends to be viewed mostly in a criminal legal system context, and there are some situations in which a person might be considered less legally culpable if her actions were influenced by trauma. Indeed, there are many ways in which the criminal legal system is already designed to take the context of a person's behavior into account when determining the person's criminal culpability (even though in practice, survivors' trauma histories are not always taken into account). Examples of how the criminal legal system is designed to account for context include prosecutorial discretion regarding what crime to charge the person with, depending on the evidence; the right to present evidence in support of long-standing legal defenses of justification or excuse; the right to present mitigating evidence; and accounting for prior convictions in charging and sentencing determinations.

In contrast to the criminal legal system, treatment or interventions are not designed to determine criminal culpability, but rather to determine what factors contributed to the harmful or potentially harmful behavior and determine how to help prevent future harm. Treatment or interventions may involve supporting a person in coping with, or recovering and healing from events or conditions that contributed to the person's own harmful behavior(s). When providing treatment or other interventions, all behavior has to be looked at in context. Trauma is relevant in a variety of situations and it is up to those working with the trauma survivor to engage with the survivor in assessing those behaviors.

CAN EXPERIENCING TRAUMA MAKE SOMEONE DANGEROUS?

Whether experiencing a traumatic event and its effects results in a person becoming more dangerous depends on a variety of factors.

At the most basic level, experiencing a traumatic event and the common effects of trauma do not inherently cause someone to become more dangerous. Traumatic events are very common, and for the vast majority of people, living with the effects of trauma does not make them more dangerous to themselves or others. For example, most of the typical trauma-related behaviors, such as displaying a flat affect or missing an appointment as a way to avoid thinking or talking about the trauma, have no bearing whatsoever on someone's dangerousness.

In certain limited situations, the effects of trauma can sometimes result in trauma survivors engaging in behaviors that put other people at risk, including their children. However, in such situations, it is also important to consider the role of institutions in creating barriers that limit trauma survivors' options for coping with trauma, as well as societal notions of who is considered "dangerous."

Further, the behaviors (including traumatic responses) of people of color, immigrants, LGBT people, low-income people, and others who are socially marginalized are more likely to be scrutinized and perceived as dangerous by practitioners and people within social institutions, even when such survivors engage in the same or similar behaviors in response to trauma as people in other social groups. As always, it is important to consider the full context of trauma survivors' lives, including when considering whether someone is "dangerous."

CAN A PERSON RECOVER COMPLETELY FROM TRAUMA, PARTICULARLY IF THEY HAVE DEVELOPED PTSD? CAN THEY EVER GO BACK TO THE WAY THEY WERE BEFORE THEY EXPERIENCED TRAUMA?

The answer to this question depends largely on whom you ask. Yes, people can recover from trauma, and the majority of people who experience traumatic events do recover.

However, many experts in the trauma field believe that it is difficult for someone to completely recover from PTSD and that there are always some lingering effects. Many practitioners in the field of trauma refer to the "new normal" as what occurs after a person is exposed to serious trauma. Such trauma survivors may have the skills to manage the trauma symptoms, but the event or events themselves in many ways change the way the person behaves, thinks, or perceives things. These changes are not necessarily bad or negative; but after a serious trauma there will be changes in the person's life.

In addition, many trauma survivors experience significant benefits from various kinds of therapies and interventions. Much research has been devoted to determining which types of therapies or interventions are most effective in helping trauma survivors reduce, manage, or heal from the effects of trauma. (http://www.ptsd.va.gov/public/treatment/therapy-med/treatment-ptsd.asp).

Part 2 — When Advocates Testify as Experts

The following section addresses common issues that emerge when advocates serve as expert witnesses and are asked to testify about trauma and its effects. It is not intended to be a complete exploration of all of the possible issues that may arise when an advocate testifies as an expert, nor does it offer specific suggested answers for advocates who testify as experts. For further information about expert testimony, please review the National Clearinghouse's Expert Witness Webinar Series recordings and resources on their website (https://www.ncdbw.org/webinars-expert-witness-series-list.)

GENERALLY, HOW IS EXPERT TESTIMONY FROM A COMMUNITY-BASED ADVOCATE DIFFERENT FROM EXPERT TESTIMONY FROM A FORENSIC PSYCHOLOGIST, PSYCHIATRIST, CLINICAL SOCIAL WORKER, OR OTHER EXPERT WHO TESTIFIES ABOUT DOMESTIC VIOLENCE AND/OR SEXUAL ASSAULT?

When describing various kinds of expert testimony in cases involving domestic violence or sexual assault survivors, it is useful to distinguish between the types of testimony that community-based advocates provide as compared to testimony from other expert witnesses who interview and evaluate the individual about whom the expert will testify.

Because advocate-experts usually are not trained clinicians, they do not conduct individual interviews with the survivor, because they are not testifying to offer an expert opinion about the person. Thus, unlike forensic experts or other clinicians, advocate-experts are not applying what they know about trauma or domestic violence to a specific person. Advocate-experts simply share what they know, based on their experience and training, in order to educate the judge or jury. It is up to the judge to decide whether the advocate-expert's testimony is admissible. If so, then in a jury trial, the jury is free to consider whether or how the testimony they heard from the advocate-expert relates to the facts of the case.

Although advocate-experts' testimony is therefore called "general" or "generic" testimony, such a characterization does not mean that advocate-experts' testimony

should necessarily imply that there is a generic, one-size fits all response to domestic violence, sexual assault, or other forms of trauma. It is acceptable (and, in fact, more accurate and thus more helpful) for advocate-experts with experience and training in working with particular groups of people to testify based on that experience and training.

For example, an advocate who works with domestic violence survivors in a rural community can testify generally as an advocate-expert regarding the common experiences of domestic violence survivors in rural areas. Such an advocate-expert could explain the context of the unique tactics of control that are available to abusive partners in rural communities, the common barriers that survivors in rural communities face, and the available resources and strategies that such survivors often utilize. Even though such testimony would still be "generic" or "general" because it does not relate to a specific individual, the testimony would not be identical to testimony from an advocate-expert who has expertise working in urban areas, on tribal land, in a particular immigrant community, or in the military, for example.

In contrast, when someone is a licensed clinician and/or has research-based expertise (including forensic psychologists, psychiatrists, marriage and family therapists, and clinical social workers), such practitioners conduct an individual interview with the person who is alleged to have experienced trauma. The purpose of such interviews is to assess whether the individual has experienced trauma and, if so, to determine the extent and nature of its effects. Sometimes, such testimony is also informed by a review of case-related records or interviews with family members or other collateral sources about the events at issue.

In such cases, the expert witness testifies based not only on their clinical or research-based knowledge about domestic violence, sexual assault, and/or trauma and its effects, but also about how, in their assessment, the individual survivor's experience relates to the expert's prior knowledge about abuse and trauma. This testimony can include common myths and misconceptions about domestic violence or sexual assault, the barriers survivors often encounter when seeking safety, and common safety strategies that survivors utilize to try to increase their safety, and how the individual survivors' experiences compare to other survivors' experiences.

HOW MIGHT AN ADVOCATE-EXPERT'S TESTIMONY ABOUT TRAUMA BE HELPFUL TO A SURVIVOR IN A COURT?

Most often an advocate-expert would be called to testify in cases in which a domestic violence survivor is in court because of something directly related to being victimized by an abusive partner. Often, the abusive partner will be on the opposite side of the case. The survivor may testify about information related to the traumatic events, often with the abusive partner sitting just a few feet away. Many trauma survivors

have a difficult time in court because this process can cause them to re-experience trauma symptoms. Not surprisingly, the entire process can create numerous challenges for survivors who must testify and, as a result, they can end up not being very effective witnesses on their own behalf and their credibility can be questioned.

An advocate-expert who describes the effects of trauma can help the judge and/or jury put the survivor's behavior and presentation in the context of trauma. Such testimony may also help explain the survivor's conduct in court — even when the advocate-expert does not specifically address that behavior. By providing needed information about the effects of trauma, an advocate-expert can help others understand the survivor's reality and ensure that the difficulties the survivor may have experienced due to being re-traumatized during the court process do not negatively impact the survivor's credibility as a witness.

Additionally, it can be useful for advocate-experts to be able to explain the resourcefulness of victims of trauma and to offer an alternative, trauma-informed analysis of trauma survivors' responses in order to help explain some of the behaviors that may otherwise seem confusing to jurors.

WHAT KIND OF EXPERTISE DO ADVOCATE-EXPERTS NEED IN ORDER TO TESTIFY ABOUT TRAUMA? ARE THERE ASPECTS OF TRAUMA THEY SHOULD NOT BE TESTIFYING ABOUT?

Advocates can testify about trauma generally, as long as they are clear in their testimony that they are not a trauma expert, but rather are speaking from their experience and knowledge of working with trauma survivors as a community-based advocate. Advocates should not testify about the neurological aspects of trauma or how the brain processes trauma unless they have specialized expertise. It would not be expected that an advocate would have that training.

SHOULD ADVOCATE-EXPERTS BE TESTIFYING ABOUT PTSD?

If the advocate is a licensed mental health professional, then talking about PTSD is probably within the scope of her license and practice. If the advocate is not a licensed mental health professional, she should not testify about PTSD, per se. The advocate can talk about trauma and its effects based on her experience with survivors, but not as an expert in PTSD. She can talk about trauma and its effects without talking about PTSD or any other diagnosis.

CAN AN ADVOCATE-EXPERT TESTIFY ABOUT TRAUMA BASED ONLY ON HER EXPERIENCE WORKING WITH SURVIVORS? DO ADVOCATE-EXPERTS HAVE TO BE FAMILIAR WITH TRAUMA RESEARCH IN ORDER TO TESTIFY AS AN EXPERT?

An advocate can testify about her experience working with trauma survivors. She must stay within the scope of her experience and training. Advocates are not expected to know all the research about trauma because they are not testifying about the field of trauma, or about how traumatic events are processed in the brain. Rather, advocate-experts are testifying about their own experience and knowledge based on working with survivors of domestic violence and/or sexual assault.

WHAT ARE COMMON QUESTIONS ABOUT TRAUMA THAT ADVOCATE-EXPERTS ARE ASKED TO ANSWER ON DIRECT EXAMINATION?

A witness is subject to "direct examination" when the attorney who called that witness asks the witness a series of questions. On direct examination, advocate-experts are often asked to describe:

- The advocate-expert's qualifications;
- A definition of trauma;
- Common responses of trauma survivors;
- How experiencing trauma affects survivors;
- The common traumatic effects of sexual and/or intimate partner violence, and how those effects are similar to or different from common responses to other traumatic events; and
- The cumulative effects of ongoing and/or lifetime exposure to trauma.

WHAT CAN AN ADVOCATE-EXPERT EXPECT ON CROSS-EXAMINATION?

Following direct examination, the opposing side will have an opportunity to cross-examine the witness. Generally, the goal of cross-examination is to discredit the witness by asking a series of leading questions (or questions that imply the answer in the way the question is asked). The cross-examination of an advocate-expert will primarily be focused on whether the advocate-expert

interviewed the specific survivor or is testifying generically. Usually, unless the advocate-expert has specific clinical expertise, advocate-experts only provide generic testimony. In addition, opposing counsel may also ask specific questions about the advocate-expert's qualifications to discuss trauma and its effects.

WHAT ARE SOME OF THE KEY RESOURCES WITH WHICH ADVOCATE-EXPERTS SHOULD BE FAMILIAR?

In general, and advocate expert should be able to provide at least two citations for any area about which she testifies. A listing of online resources about trauma is included in Part 4.

CAN ADVOCATE EXPERTS TALK ABOUT TRAUMATIC MEMORY? WHAT IF THEY ARE ASKED WHY TRAUMATIC MEMORY DIFFERS FROM "REGULAR" MEMORY?

When testifying, an advocate should always stay within the scope of her experience and training. If an advocate has had specific training about traumatic memory, then the advocate can testify about that; but most advocates do not have this training.

When preparing to testify, it is helpful for advocate-experts to talk with the attorney who has requested the testimony about how to respond to questions that are outside the scope of the advocate's experience and training.

MIGHT ADVOCATE EXPERTS GET ASKED ABOUT WHETHER THEY THINK A TRAUMA SURVIVOR IS TELLING THE TRUTH?

Because advocate-experts are providing general testimony about trauma and the experiences of trauma survivors, they should not be asked about a particular trauma survivor's veracity. Advocate-experts — and most other expert witnesses — should never be asked whether they think someone is telling the truth; such a question is not allowed in most kinds of legal proceedings. However, advocate-experts may be asked if they always believe everything people claiming to be victims of violence tell them. For example, advocate-experts may be asked, "Isn't it your training to believe your client and assume you are being told the truth?" An advocate-expert also should be prepared to be cross-examined about "possibilities" or "hypotheticals." In other words, advocate-experts might encounter questions like, "Hypothetically speaking, if a person gives inconsistent statements about a significant event, another person would be reasonable in concluding that the person is not being truthful, right?"

Questions about trauma survivors' inconsistent statements are very common for a number of reasons. For one, challenging an opposing party's credibility in court is sometimes the most viable strategy available to the other party in a litigation setting. Also, because the alleged acts of harm are rarely recorded (and, even when they are, such recordings do not reveal the overall context in which the acts occurred, such as a history of ongoing abuse), there usually are multiple accounts of what happened, and the jury or judge must decide which story to believe.

In addition, because survivors' efforts to hold abusive partners accountable through the court system often have the effect of escalating abusive partners' threats and harmful behaviors against survivors, many survivors determine that the safest strategy is to withdraw from participating in the court process. To withdraw their participation, survivors often are required to say that their initial account of events was untrue or exaggerated (or, survivors' withdrawal from participations simply leads people within the court system to incorrectly draw such conclusions). Such protective self-removal from participation in the courts contributes to the common misperception that it is common for people to make false allegations of abuse in order to gain a particular advantage in court. These misperceptions in turn contribute to a general culture of doubting people's allegations of abuse, which creates ongoing challenges for survivors who do come forward to seek assistance and support.

Given this context and the prevalence of questions regarding survivors' credibility, it is helpful for advocate-experts to be prepared to describe their process for assessing the credibility of the people for whom they advocate. Rather than being trained to "believe everyone's claims" of abuse, for example, advocates generally are trained to listen carefully to a person's account of what has happened; ask questions to more fully understand the person's experience; and offer support, assistance, and resources relevant to the person's experience. While every person's experience is unique, because trauma tends to affect people in similar ways, advocates become very familiar with the common effects of experiencing trauma the more stories they hear. Thus, experienced advocates develop a "mental database" of survivors' stories and experiences. New accounts are heard and analyzed in light of that database of stories. Advocates learn to ask thoughtful, informed questions to gather more information if parts of someone's story do not fit with what the advocate knows about abuse and trauma. In this way, advocates are always assessing the credibility of the people with whom they work. Because trauma survivors' accounts of the traumatic event or events often vary from one telling to the next, and are rarely told in a coherent, chronological way, inconsistencies in a survivor's story would not negatively affect the survivor's credibility for advocates who are experienced in working with trauma survivors.

The authors and the National Clearinghouse for the Defense of Battered Women hope we have addressed some of your questions about trauma and its effects and that we have provided you with additional ideas on how best to explain trauma and its effects if called as an expert witness. We also understand that as you read this piece you may have found yourself having additional questions, some of which might not have been addressed here. We see that as a good sign! It is our hope that this piece will serve as a starting point and will encourage you to talk with your coworkers and others about how to better understand and explain trauma and its effects.

While there has already been a lot of research about trauma and its effects, we know there is still much to learn. The study of trauma is a field that constantly changing and growing. It is our hope that community-based advocates who work with domestic violence and sexual assault survivors will continue to play a key role in helping researchers, practitioners, and trauma survivors better understand survivors' experiences of and responses to trauma. Additionally, we hope that community-based advocates who testify as expert witnesses will continue to provide needed education about trauma and its effects to judges, jurors, and others, so they, too, will better understand the realities of trauma survivors' lives.

You will find a listing of additional resources follows at the end of this document (Part 4), which includes many resource centers that regularly produce fact sheets and research summaries, offer continuing education opportunities, operate listservs, and organize conferences.

If you have additional questions about trauma and its effects, want to share information about trauma and its effects not covered above, and/or if you have developed effective ways of explaining trauma and its effects to others, the National Clearinghouse for the Defense of Battered Women would like to hear from you.

Part 3 — Basic Trauma Terminology and Concepts

AVOIDANCE
is one of the common effects of experiencing a traumatic event, and is one of the criterion symptoms for a diagnosis of Posttraumatic Stress Disorder. Avoidance involves a persistent effort to avoid distressing trauma-related thoughts, feelings, or external reminders (such as people, places, conversations, activities, objects, or situations).

COMPLEX PTSD
is a fairly new term that emerged out of the work of Dr. Judith Herman. The concept refers to the complicated traumatic experiences of people who experience prolonged, repeated trauma, such as people who are subject to long-term domestic violence, child physical or sexual abuse, sex trafficking, prisoner of war or concentration camps, or similar situations where the survivor is held in a state of physical or emotional captivity and unable to escape the control of the perpetrator. People who experience chronic, long-term trauma often report additional symptoms alongside formal PTSD symptoms, such as changes in their self-concept and the way they adapt to stressful events (http://www.ptsd.va.gov/professional/PTSD-overview/complex-ptsd.asp).

CUMULATIVE TRAUMATIC STRESS
is a result of a person having experienced multiple traumatic events during the person's lifetime, so that the effect of a new trauma is added to the unresolved issues from previous traumas.

DISSOCIATION
can take the form of emotional numbing and/or states where the person experiences a sense of detachment from self (i.e., depersonalization). In states of depersonalization, there is a persistent or recurrent experience of feeling detached from one's mental processes or body, as if one is outside her own body observing. This dissociative state is common in trauma survivors, who often describe feeling "like I was watching someone else" or "like sleep walking" or "being on automatic pilot." This response to severe trauma when the psyche "splits off" is an effort to protect the person from the overwhelming feelings associated with the traumatic event(s). It is an unconscious psychological phenomenon frequently associated with domestic violence survivors, molested children, or others in severe traumatic situations. This dissociative state can even take the form of traumatic amnesia, where the person has no memory at all for certain events or actions. Even a series of actions that are very complex can be executed while in a state of traumatic amnesia.

FLASHBACKS
are fragmented sensory experiences involving affect (feelings), vision, tactile sensations, taste, smell, and the auditory and motor systems. Flashbacks are not only visual, and often lack a narrative component. Flashbacks are frequently triggered by something in the environment, often a sensory event such as a scent or image. When a flashback occurs, it is as if the person is re-experiencing the event that occurred previously. This is not a conscious re-experiencing, but is triggered by unconscious sensory memories.

FROZEN FRIGHT
refers to the physiological response that can occur during a traumatic event, and is especially prevalent for rape survivors. There is often a point in time when the traumatized person actually feels unable to move, scream, fight back, or engage in any of the behaviors that are stereotypically expected. This is technically referred to as "tonic immobility," which is a kind of trauma-induced paralysis in response to extreme fear. Up to 50% of rape victims experience frozen fright (Campbell, R. (2012). The Neurobiology of Sexual Assault: Implications for First Responders in Law Enforcement, Prosecution and Victim Advocacy. Webinar presented by the National Institute of Justice). Experiencing frozen fright is more common if there is a prior history of sexual assault or abuse.

HEIGHTENED AROUSAL
is one of the common effects of experiencing a traumatic event, and is one of the criterion symptoms for a diagnosis of Posttraumatic Stress Disorder. Heightened arousal is a state that can result in difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hyper-vigilance, or exaggerated startle response. It is important to note that the response is not always inaccurate; sometimes a person's heightened state of arousal is because there really is something dangerous in the environment to attend to.

HEIGHTENED SENSE OF DANGER
is a high alert that a person experiences, usually based on past events, that causes the traumatized person to perceive a greater amount of danger in a situation than someone would who has not experienced prior trauma. The trauma survivor may be reacting to behaviors in another that would appear benign or innocent to an outsider, but which have special relevance to the trauma survivor who experiences them as signs or signals that danger is increasing. Again, this response is based on past experience and is often based on an understanding of actual danger.

HYPER-VIGILANCE
is where the person becomes acutely aware of their environment, as if scanning for something dangerous to occur. It is one of the common effects of experiencing a

traumatic event, and is an example of a "heightened arousal" symptom, one of the criterion symptoms for a diagnosis of Posttraumatic Stress Disorder.

POSTTRAUMATIC STRESS DISORDER (PTSD)
is an psychological diagnosis defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association. In the fifth edition of the DSM (DSM-5), PTSD is defined as a disorder that results from exposure to actual or threatened death, serious injury or sexual violation, where the individual directly experiences the traumatic event; witnesses the traumatic event in person; learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related). The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning. PTSD is not considered to be the physiological result of another medical condition, medication, drugs or alcohol. To be diagnosed as having PTSD, a person must have behavioral symptoms in each of four distinct diagnostic clusters (re-experiencing, avoidance, negative cognitions and mood, and arousal) that last for more than a month (https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd).

TRAUMA
is, in everyday language, an individual's emotional and physiological response to an event, series of events, or set of circumstances where the person experiences or witnesses a threat to her or another person's life or physical integrity which has lasting negative effects on the person's functioning and physical, social, emotional, or spiritual well-being.

TRAUMATIC AMNESIA
refers to those pieces of traumatic events that are either never encoded in a person's memory, or are stored in a place where the person does not have access to them. This most frequently happens with traumatized children, although it can also happen with adults. Essentially, traumatic amnesia refers to that information (usually a piece of information) for which the person has no recall. Sometimes this information is lost forever and sometimes it will spontaneously pop up when triggered by some other event. It is not the result of the person willfully wanting to forget or trying to avoid the memories, but rather is a result of the way that the information is processed in the brain.

TRAUMATIC MEMORY
has been researched extensively. When a victim of trauma attempts to recall certain traumatic events, the memories are often presented out of order, aspects are forgotten (i.e., the person has no conscious ability to recall the information), and/or the person may describe the event differently from one telling to the next as an unconscious psychological coping mechanism. Because of how the brain processes traumatic events, variation from one telling to the next is to be expected when recounting such events. Additionally, there are some things that are never remembered, even over a period of many years. This is because traumatic memory is very different from "normal," non-traumatic memory.

In typical, non-traumatic situations, the brain encodes and stores information, making it ready for retrieval. In traumatic situations, information is not encoded or stored in any systematic fashion. It is more likely to be stored in a random way, making retrieval very sporadic and difficult. Thus, it is quite typical of trauma survivors to recount their traumatic memories out of sequence, with significant gaps, and for each account of the events to be slightly different.

Memory is a very complex operation. There are four stages of memory: intake, storage and coding, rehearsal, and retrieval. There are also two identified forms of memory: explicit and implicit. Explicit memory is the narrative memory, or one's ability to consciously recall facts and events. Implicit memory is primarily related to the senses, and refers to memory that does not have a narrative or conscious content. Someone may react strongly to a specific smell without having an explicit memory to explain her reaction to that smell.

TRAUMATIC STRESS
results from traumatic events, which are shocking and emotionally overwhelming situations that may involve actual or threatened death, serious injury, or threats to physical integrity
(http://www.istss.org/public-resources/what-is-traumatic-stress.aspx.

Part 4 — Resources

The National Clearinghouse for the Defense of Battered Women hosts a webinar series about expert witnesses, which includes audio recordings and related training materials: https://www.ncdbw.org/webinars-expert-witness-series-list.

The National Center on Domestic Violence, Trauma & Mental Health is a great resource for community-based advocates wanting more information the interconnections between domestic violence, trauma & mental health. The Center provides training, support, and consultation to advocates, mental health and substance abuse providers, legal professionals, and policymakers as they work to improve agency and systems-level responses to survivors and their children. Their work is survivor defined and rooted in principles of social justice. http://www.nationalcenterdvtraumamh.org/about/.

In addition to the many resources available through their website, they have also developed a comprehensive **VAWNet Special Collection** on trauma-informed responses: http://vawnet.org/sc/trauma-informed-domestic-violence-services-understanding-framework-and-approach-part-1-3.

OTHER ON-LINE RESOURCES (LISTED ALPHABETICALLY) INCLUDE:

The **Childhood Violent Trauma Center** aims to increase the capacity of individuals and communities to reduce the incidence and impact of violence on children and families; to train and support the professionals who provide intervention and treatment to children and families affected by violence; and, to increase professional and public awareness of the effects of violence on children, families, communities and society: http://www.nccev.org/

The Indian Country Child Trauma Center (ICCTC) was established to develop trauma-related treatment protocols, outreach materials, and service delivery guidelines specifically designed for American Indian and Alaska Native (AI/AN) children and their families as part of the National Child Traumatic Stress Network: http://icctc.org/

The International Society for Traumatic Stress Studies (ISTSS) is dedicated to the discovery and distribution of knowledge about policy, program, and service

initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences. ISTSS publishes the *Journal of Traumatic Stress* and offers courses for continuing education: http://www.istss.org/

National Center for Post-Traumatic Stress Disorder (PTSD) of the U.S. Department of Veterans Affairs is a center for research and education on the prevention, understanding, and treatment of PTSD. The National Center for PTSD may be of particular interest to domestic violence programs and service providers working with current and former members of the military, but also has useful resources regarding PTSD generally: http://www.ptsd.va.gov/

National Center for Trauma-Informed Care (NCTIC) is a Substance Abuse Mental Health Services Administration (SAMHSA)-sponsored national center focusing on the implementation of trauma-informed approaches across a variety of health and human services: http://beta.samhsa.gov/nctic

National Center on Domestic Violence, Trauma, and Mental Health develops and promotes accessible, culturally relevant, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being. They have developed many resources that may be relevant to advocates who testify as experts: http://www.nationalcenterdvtraumamh.org/

National Child Traumatic Stress Network (NCTSN) was established by Congress in 2000 and funded by SAMHSA as a collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States: http://www.nctsn.org/

National Disaster Technical Assistance Center (DTAC) of SAMHSA assists States, Territories, Tribes, and local entities with planning to help organizations prepare for and respond to both natural and human-caused disasters. DTAC may be of particular interest to domestic violence programs and services with a focus on trauma-informed disaster planning and response: http://beta.samhsa.gov/dtac

PILOTS: Published International Literature on Traumatic Stress is a subscription-based bibliographic database maintained by the National Center for PTSD (sponsored by the U.S. Department of Veterans Affairs) that includes free citations and previews to all literature on PTSD and other mental health consequences of traumatic events: https://search.proquest.com/pilots/index?accountid=28179.

PTSD Overview, a 45-minute online course from the National Center for PTSD, is a continuing education credit course (available for free online) outlines the DSM-5 diagnostic criteria, explains who is most at risk for developing PTSD, and describes

the most effective treatments:
https://www.ptsd.va.gov/professional/continuing_ed/ptsd_overview.asp