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Survivor Insight: A Study of Family, Friend, and Community Response to Interpersonal Violence

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ABSTRACT

The purpose of this study was to examine the perspectives of survivors of trauma concerning their family, friend, and community responses to their trauma. Using a community-based, participatory action framework, a measure was developed and distributed to 351 randomly drawn survivors of interpersonal violence. The majority of participants indicated that they were never or rarely helped or protected at the time they first experienced the trauma. Several significant correlations were found between participants' perceptions of their own healing and the responses of people in their lives. Many respondents also indicated that people do not know how to help survivors heal and that the general public does not understand how trauma affects people. The results are discussed within the framework of developing supports for trauma survivors that include trauma-informed family, friends, and community. Questions for further research and implications for professional practice and trauma-informed communities are discussed.

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The negative health outcomes associated with violence, abuse, and other forms of trauma are well documented and are compounded by how individuals and communities approach and respond to abuse survivors (Bloom, 2013). Survivors have a unique and deep understanding of abuse and direct knowledge about how natural systems (i.e., family, friends, and the community at large) have responded to their abuse. Given this, survivors' insights should be very well represented in any effort to create trauma-informed communities. As demonstrated in the mental health consumer movement (Nelson, Ochocka, Janzen, & Trainor, 2006) and as exemplified in the principles of participatory action research (Fernandez-Pena, Moore, & Goldstein, 2008), trauma survivors' knowledge and insights are vital toward the establishment of a new social response to trauma, a response that reduces help-seeking barriers and assists family and friends' abilities to reliably provide trauma healing support. Our

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assumptions are that survivors of abuse and neglect have legitimate and expert knowledge about trauma healing and that this collective perspective should be actively pursued (Cortez et al., 2011).

Child and adult survivors often encounter denial and minimization when they disclose their abuse, are frequently blamed for instigating their own victimization, and often endure the abuse and its memories in a shroud of secrecy due to many factors that inhibit disclosure (Burstow, 2005). When persons who have experienced abuse do seek support, they most often turn to family and friends (Sylaska & Edwards, 2014; Taket, O'Doherty, Valpied, & Hegarty, 2014; Todahl, Walters, Bharwdi, & Dube, 2014). Family and friends are often in the best position to help survivors increase their safety, cope with their abuse, and support the healing process. Trauma-informed family and friends are needed to better ensure that survivors of abuse much more frequently receive healing attention at the time of disclosure and beyond.

The purpose of this study was to explore survivors' perspectives about family, friend, and community responses to their trauma and key elements of trauma healing. This mixed methods study addressed the following four questions:

(1) How did family and friends and other community members respond to participants' abuse, both at or around the time it was occurring and later in life?
(2) What is the relationship between survivor-perceived supportive responses and survivor reports of healing from abuse?
(3) What do survivors believe family, friends, and others need to know about trauma to be helpful?
(4) What do survivors believe family, friends, and others need to do to promote healing?

Background and setting

This study occurred in the context of a community–campus partnership. Our partnership included a diverse array of community members, researchers, and students. Primary institutional partners included the Trauma Healing Project (THP) and faculty and students at the University of Oregon. The THP is a private, nonprofit, social justice organization led by survivors of abuse serving the greater Eugene/Springfield, OR, community. The vision of the THP is "a community where any person or group in our community impacted by violence, abuse, or other trauma is supported to recover and heal." The THP conducts participatory action research, provides direct service support groups and movement-based healing, and offers community-based education (e.g., a public-access library, digital storytelling workshops, and trauma-informed

trainings for family and friends). The research team involved in this study, titled Survivor Voices, included University of Oregon faculty, graduate students, THP employees, and community members. Most research team members identify as survivors of abuse or violence. Finally, the THP endorses the principles of trauma-informed services as described by Elliott, Bjelajac, Fallot, Markoff, and Reed (2005). This includes, for example in health care settings, intentional practices that promote key messages to staff and patients, such as (a) we know that many of our patients and staff are experiencing or have experienced trauma; (b) you can talk about these experiences here (i.e., addressing trauma is a part of your health care needs); (c) we are competent to support you in a safe, skilled, and nonjudgmental manner; and (d) your trauma-related symptoms are a natural response to mistreatment (Davies, Todahl, & Reichard, 2015).

Method

Survivor Voices is a community-based, participatory action, mixed-methods random-digit telephone survey ($N = 351$). A concurrent mixed-methods design (Molina Azorin & Cameron, 2010) was selected to develop a more nuanced understanding of the answers to our research questions (Tashakkori & Creswell, 2007) and for the purposes of exploration and confirmation or disconfirmation of findings (Wiggins, 2011). Qualitative and quantitative data were collected concurrently. Qualitative and quantitative analysis occurred after all data were collected; qualitative questions were not iterative, and all participants responded to the same open-ended questions. Additionally, to more fully understand survivors' perspectives about trauma and trauma healing, the research team included survivors at all levels of the study—from development of the research questions to dissemination of findings. The survey included 68 closed-ended and 10 open-ended items. Trauma survivor research members participated in decision making related to all aspects of the study, including human subject protection, item construction, survey design, focus group item development, data analysis, and dissemination. The survey was exploratory and the instrument is not normed. Human subject approval was granted by the university's institutional review board.

Survey development

Survey items were constructed by Survivor Voices research team members and were designed to elicit survivors' insights relative to the research questions. Survey items were first developed in a pilot study (Todahl et al., 2014). This process included a literature review, five focus group interviews with trauma survivors to develop study questions and the measure, and a convenience sample pilot study ($n = 82$). Following this, a principal component analysis eliminated items that were highly correlated and conceptually similar.

The final survey included 68 closed-ended and 10 open-ended items. Closed-ended items assessed four domains of survivor trauma: (a) abuse and violence experienced by participants; (b) response by family, friends, and community; (c) help seeking and response; and (d) healing.

Sampling and survey administration

The Survivor Voices survey was conducted using a contracted professional call center, drawing from a random sample of all working landline phone numbers in the metropolitan Eugene/Springfield, OR, area. All residents of Eugene/Springfield with a residential phone had an equal chance of being selected. Residents were eligible to participate if they were at least 18 years of age and responded "Yes" to the question, "Have you ever experienced or witnessed any form of abuse or violence as a child or adult?" Interviewers provided each participant with a definition of neglect and abuse. Physical abuse was defined as "acts of a physical nature, such as pushing, slapping, throwing items, and breaking things." Sexual abuse was defined as "unwanted sexual contact or forced activities of a sexual nature, such as touching private body parts." Verbal abuse was defined as "statements that harm your well-being, such as being told you are ugly or being told you are incapable of doing something." Interview length averaged 21 min.

The Council of American Survey Research Organizations (CASRO) response rate, a proportion of the eligible sample that has completed a survey (Carlson, 2013), was calculated by dividing completed interviews by the total number of eligible respondents. Additionally, in the course of calling, all business, government, and other nonresidential phone numbers in the sample were removed. We assumed that 32% of our "unknown" viable numbers (e.g., busy signal, answering machine; n = 5,648), should they have been reached, would have met eligibility criteria. This was calculated based on previously documented local abuse rates (Oregon Department of Human Services, 2004). Given this, our CASRO Response Rate 3 was 31.5%. Our CASRO Cooperation Rate 1 was 89.1%, based on a calculation of participants who met eligibility criteria, began the interview, and completed the full telephone interview. Given CASRO response rate, sample size, and population of interest, survey results can be conservatively generalized to the Eugene/Springfield community with an error rate of ±5.2%.

Data analysis

Quantitative analysis

The quantitative analysis in this study was largely descriptive. Group t tests, correlations, chi-square tests, and odds ratios were used to describe the relationship between survey items and demographic characteristics (e.g.,

gender). Magnitude of the differences in means from *t* tests were summarized using Cohen's *d* statistic with the convention .20 = small, .50 = medium, and .80 = large. Magnitude of correlations was calculated with .20 = small, .30 = medium, and .50 = large (Cohen, 1988), and magnitude of odds ratios used conventional ranges of 1.48 = small, 2.48 = medium, and 4.28 = large (Lipsey & Wilson, 2001).

Qualitative analysis

Two open-ended items, drawn from 10 open-ended items included in the survey overall, were analyzed for this study. The analyzed items focused directly on survivors' recommendations for ways to better understand trauma and trauma support. These items read as follows:

(1) What do you think is most important for people to understand about trauma?
(2) What kind of support do you think is important to help survivors of trauma?

These questions were selected for initial analysis because they most directly map to Research Questions 3 and 4. The other qualitative items addressed a range of healing, harm, and trauma-response questions, including, for instance, "At the time when you were first being abused, what were some of the things that helped you get through it? Overall, what helped you the most? And, overall, what has been the most unhelpful?"

Research team members were trained in qualitative analysis by the second author. Our process consisted of open coding and theme identification (Strauss & Corbin, 1998). We worked as a large group on the first question to refine our procedures and to ensure a common understanding of qualitative analysis. We read through the compiled responses, identified code categories, and brainstormed possible themes represented in the responses. Once we felt comfortable that we had developed a consistent process, we divided into groups of two. The individual groups met on their own to continue open coding, to identify themes, and to select representative quotes. Each group met on at least three occasions to more fully understand participant responses, to expand and refine emerging themes, and to distill findings.

The initial codes selected by each research subgroup were compared to the other previously coded phrases identified by each of the other subgroups. Next, through a process of axial coding, the distinct codes were categorized to reflect the commonalities among the codes (Harry, Sturges, & Klingner, 2005). Through the researchers' discussion of codes and participant feedback, the themes and subthemes were collapsed into a more succinct coding scheme. The final coding scheme included six main themes and 19

subthemes. In this last level of analysis, we examined the relationship between these themes and subthemes (thematic analysis) and collapsed the data into two domains and seven themes. For example, Research Question 3 (What do survivors believe family, friends, and others need to know about trauma to be helpful?) generated multiple codes related to the theme that abuse is common and could happen to anyone. These codes included, for instance, "a lot," "all the time," "many people," "people you wouldn't imagine," "it's the state of the world," "anyone, common," "so common it's normal," "didn't bring it on," "not weak," "didn't ask for it," and "not because you are sick." These codes all contributed to the theme: Trauma is widespread and could happen to anyone. Subthemes, themes, and the domains were reached by consensus. Decision making was inclusive and democratic across the analysis process (Cortez et al., 2011), including selection of illustrative verbatim quotes presented in the results section of this article.

Results

Quantitative results

Demographics

The 351 study participants were mostly female (n = 248, 71%), White (n = 306, 87%), and 50 years of age or older (n = 233, 66%). Most attended some college (n = 264, 75%), with 34% earning a bachelor's degree or greater, and most resided in a household with an annual income less than $50,000 ($n$ = 224, 64%). Study participant and local demographic data largely matched (e.g., similar median income, percent reporting as White [87.2% of participants, 91.5% in local community]). Participants were overrepresented by gender (71% female participants, 51% in local community), by those who have completed at least a bachelor's degree (35% among participants, 26% in local community), and age (approximately 22% of participants reported as 65+, 15% in local community). Please see Table 1 for demographics of the sample.

Abuse and violence experienced by participants

Among all participants, 45% were first abused when they were under 6 years old; 21% were first abused between the ages of 7 and 12; and 77% were first abused prior to age 18. A summary of the abuse and violence experienced by study participants is shown in Table 2 (response options of "yes" or "no"). Over 80% (n = 290, 81%) reported being physically abused, 47% (n = 166) experienced sexual abuse, 89% (n = 311) reported being verbally abused, and 82% (n = 289) witnessed verbal abuse in their household. Neglect, defined as "basic human needs such as affection, food, or shelter were not provided for

Table 1. Demographic characteristics.

Characteristic	*n*	%
Gender		
Female	248	70.7
Male	100	28.5
Other	1	0.3
Did not respond	2	0.6
Age		
18–29 years	19	5.4
30–39 years	39	11.1
40–49 years	57	16.2
50–59 years	114	32.5
60–69 years	83	23.3
70 or more years	36	10.3
Did not respond	3	0.9
Education		
Grade school or less	8	2.3
Some high school	17	4.8
High school diploma or GED	60	17.1
Some college, no degree	90	25.6
Associate's degree (2 years) or specialized training	53	15.1
Bachelor's degree (BA, BS, AB)	68	19.4
Graduate degree	53	15.1
Did not respond	2	0.6
English is first language	340	97.1
Race		
White or Caucasian	306	87.2
American Indian or Alaskan Native	7	2.0
Asian or Pacific Islander	4	1.1
Hispanic or Latino	8	2.3
Mixed	3	0.9
Other	14	4.0
Did not respond	9	2.6
Household income		
$9,999 or less	50	14.2
$10,000–$19,999	48	13.7
$20,000–$34,999	66	18.8
$35,000–$49,999	60	17.1
$50,000–$74,999	46	13.1
$75,000–$99,999	34	9.7
$100,000 or more	36	10.3
Did not respond	11	3.1
Currently receiving government income support (excluding retirement pensions)?		
Yes	86	24.5
No	259	73.8
Did not respond	6	1.7
As a child were you ever in foster care?		
Yes	20	5.7
No	331	94.3
Have you ever spent time in juvenile detention?		
Yes	27	7.7
No	323	92.1
Did not respond	1	0.2
Have you ever considered yourself homeless?		
Yes	102	29.1
No	248	70.7
Did not respond	1	0.2

Note: GED = general education diploma.

Table 2. Summary of abuse and violence experienced by participants.

	Yes		No	
Question	*n*	%	*n*	%
Have you ever experienced someone being verbally violent or abusive toward you?	311	88.6	38	10.8
Have you ever experienced someone being physically violent or abusive toward you?	290	82.6	60	17.1
Have you ever witnessed someone being verbally violent or abusive toward someone in your household or family?	289	82.3	62	17.7
Have you ever witnessed someone being physically violent or abusive toward someone in your household or family?	261	74.4	90	25.6
Have you ever lived with someone who was a veteran of active combat duty or someone who was directly engaged in or exposed to war?	166	47.3	182	51.9
Have you ever experienced someone being sexually violent or abusive toward you?	165	47.0	184	52.4
Did you experience neglect as a child?	127	36.2	219	62.4
Was your mother or primary female caregiver ever physically or sexually abused during the time you lived with her?	108	30.8	233	66.4
Have you ever witnessed someone being sexually violent or abusive toward someone in your family?	75	21.4	275	78.3
Have you ever directly experienced or witnessed an employee in an institutional setting, such as a hospital, being physically or sexually abused?	48	13.7	300	85.5
Are you a veteran of active combat duty or were you directly engaged in or exposed to war?	28	8.0	321	91.5

extended periods of time," was experienced by 36% of participants during childhood, and 31% reported that their mother or primary female caregiver had experienced physical or sexual abuse.

Some participants experienced more trauma than others

An exposure to trauma score was created by summing the number of trauma types personally experienced by participants (see Table 2), with each trauma endorsed "yes" counting as one point. On average, participants experienced 5.3 (SD = 2.0) traumatic events. Participants who ever lived in foster care had significantly more, $t(349) = 4.98$, $p < .001$, $d = .76$, trauma experiences (M = 7.6, SD = 1.5) compared to those who did not live in foster care (M = 5.9, SD = 2.3), with the difference associated with a large effect. Participants that ever were homeless had significantly more, $t(349) = 4.18$, $p < .001$, $d = .49$, trauma experiences (M = 6.8, SD = 2.3) compared to participants who were never homeless (M = 5.7, SD = 2.3), with the difference associated with a medium effect.

Response at time of abuse

A majority of the sample (n = 167, 48%) indicated that when they first experienced abuse they were never helped or protected. Nineteen percent of participants (n = 68) reported they were rarely helped or protected when they were first abused on a 4-point scale (with response options of *never, rarely, sometimes*, and *often*). Females were significantly more likely, $\chi^2(348) = 11.60$, $p = .041$, to report never being helped when they first experienced abuse (n = 130, 52%) compared to their male counterparts

(n = 36, 36%). People who did provide support at the time of first abuse were most often adult family members (n = 95), child siblings (n = 37), child friends (n = 16), and adult nonfamily members (n = 13).

Overall response and support

Participants had mixed response rates related to current support from family, friends, and the community at large (see Table 3). A large majority of respondents on a 4-point scale (response options of *strongly disagree, disagree, agree*, and *strongly agree*) reported that, when they chose to talk about their traumatic experiences, people listened with compassion (n = 284, 81%), and a moderate majority agreed or strongly agreed that people understand the impact of the trauma on their life (n = 202, 58%). Many participants (n = 195, 56%) disagreed or strongly disagreed that people in their lives know how to help them heal from their trauma. Many participants (n = 243, 69%) also disagreed or strongly disagreed that the general public understands how trauma affects people, and 81% (n = 283) disagreed or strongly disagreed that the general public knows how to help trauma survivors.

Services and supports

Nearly the entire sample (n = 332, 95%) received at least one of the trauma-related services listed in Table 4, and on average 3.3 (SD = 1.9) services were received (response option of "yes" or "no"). The most frequent service endorsed was having talked or worked with a mental health provider (n = 271, 77.2%). Of those, 60% first did this as an adult, and 87.5% did so voluntarily. Prescription medication for "mood management" was the second most frequent service received (n = 218, 62.1%), followed by participation in

Table 3. Summary of response by family, friends, and community.

	Never		Rarely		Sometimes		Often	
Question	*n*	%	*n*	%	*n*	%	*n*	%
When you first experienced any of the abuse or violence just mentioned, how often did anyone try to help or protect you?	167	47.6	68	19.4	45	12.8	41	11.7
	Strongly disagree		Disagree		Agree		Strongly agree	
	n	%	*n*	%	*n*	%	*N*	%
When I have talked about my traumatic experiences, people have listened to me with compassion.	9	2.6	30	8.5	197	56.1	87	24.8
When I talk about my traumatic experiences, people understand the impact of trauma on my life.	20	5.7	91	25.9	148	42.2	54	15.4
People have known how to help me heal from my traumatic experiences.	38	10.8	157	44.7	105	29.9	19	5.4
The general public understands how trauma impacts people—they get it.	74	21.1	169	48.1	73	20.8	11	3.1
The general public knows how to help people heal from trauma.	73	20.8	210	59.8	42	12.0	6	1.7

Table 4. Summary of help seeking.

	Yes		No	
Question	*n*	%	*n*	%
Have you ever talked to or worked with a mental health provider?	271	77.2	76	21.7
Have you ever attended or participated in a support group run by a professional?	171	48.7	177	50.4
Have you ever attended or participated in a support group run by peers?	116	33.0	231	65.8
Have you ever been admitted to a residential mental health program at any facility, including a hospital?	50	14.2	298	84.9
Have you ever attended a residential substance abuse treatment program?	43	12.3	308	87.7
Have you ever participated in outpatient or community-based substance abuse treatment?	58	16.5	287	81.8
Have you ever taken a medication prescribed to you to help with things like anxiety, depression, or to stabilize mood?	218	62.1	130	37.0
Have you undergone electroshock or electroconvulsive therapy?	3	0.9	346	98.6
Have you ever used some form of body-focused or movement therapy such as yoga, meditation, physical therapy, or dance?	211	60.1	138	39.3

some form of body-focused or movement therapy, such as yoga, meditation, dance therapy, or mediation (n = 211, 60.1%). Nearly half of all participants (n = 171, 48.7%) have attended a professional-led support group, and 33% (n = 116) have attended a peer-facilitated support group.

Community response and trauma healing

Participants were asked about the degree to which they agreed with the statement, "I can heal from the trauma I have experienced." Response options included *strongly agree* (n = 141, 40%), *agree* (n = 168, 48%), *disagree* (n = 24, 7%), *strongly disagree* (n = 5, 1%), and *don't know* or did not answer (n = 13, 4%). Participants were also asked whether they believe that they have healed from the trauma they experienced. Response options included *completely healed* (n = 82, 23%), *mostly healed* (n = 151, 43%), *somewhat healed* (n = 97, 28%), *not at all healed* (n = 13, 4%), and *don't know* or did not respond (n = 8, 2%). Taken together, 65% of participants (n = 233) indicated they were mostly or completely healed from the trauma they experienced.

Logistic regression models, controlling for number of traumatic experiences and age of first trauma, were used to predict relationships between participants' perceptions of their own healing and responses to their trauma by people in their lives, including family and friends. For each one-unit increase in perception of trauma support, computed as the mean of the last five items in Table 3 (α = .70), participants were 3.4 times more likely to report they agreed or strongly agreed that they were healed from their trauma exposure and 7.6 times more likely to report they agreed or strongly agreed that they could heal from the trauma they experienced. The observed odds ratios are associated with a large effect size. Despite the high service utilization rates, this study found no correlation between services used and healing rates.

A high percentage of participants (81%, n = 284) reported that when people in their lives such as family and friends listened, they did so with compassion. In addition, 58% (n = 202) agreed or strongly agreed that people in their lives understand the impact of trauma. By contrast, a full 69% (n = 243) disagreed or strongly disagreed that the general public understands how trauma affects people. When asked whether people in their life know how to help, 56% (n = 195) of participants disagreed or strongly disagreed. When this same question involved the general public, 81% (n = 283) disagreed or strongly disagreed. Among all participants, 95% (n = 332) had sought out some form of trauma healing support.

Qualitative findings

The open-ended items in this mixed-methods study allowed survivors to elaborate on several issues, including what they believe people should know about trauma to be helpful and the kind of support that is important for healing. This article focuses on two of the open-ended questions. Analysis of the first question, "What do you think is most important for people to understand about trauma?" produced four themes: (a) trauma is widespread and can happen to anyone; (b) trauma can have a lasting and damaging impact; (c) silence and secrecy about trauma are common and harmful; and (d) quality of attitude can affect healing. The second open-ended question, "What kind of support do you think is important to help survivors of trauma?" also produced four themes: (a) the need for supportive and informed family, friends, and community members; (b) access to supportive and informed professionals and services; (c) the need for connection with and support from other survivors; and (d) listening and the quality of listening. A total of 339 participants responded to the open-ended items in this analysis.

Question 1: Important to understand

Participants were asked to describe the most important things people should understand about abuse and trauma to be helpful to survivors.

Trauma is widespread and can happen to anyone. Participants urged community members to believe and accept that abuse and trauma occur. Many participants (n = 55) were emphatic about the importance of broader community recognition and acceptance of abuse and trauma, as reflected by one survivor: "Please believe me. Please believe that abuse exists. Believe that I am not just making up stories. I didn't imagine it. It really did happen." Participants also emphasized the importance of understanding that anyone can be abused:

- "Listen and know that people are telling the truth. These things happen. It happens to people that you never would imagine."
- "It could happen to you, trauma is a part of life sometimes, so there's no guarantee that it won't happen to you. It may."

Trauma can have a lasting and damaging impact. Participants also emphasized adopting attitudes that recognize that the negative impact of abuse and trauma can be as real as a physical injury or change a person's life dramatically. For example:

- "[Trauma] can be damaging like a severe physical injury, like one that would require surgery or casting."
- "It doesn't take very much to have a lasting impact on your life. Even just a few incidents, it really changes how you see things."

Silence and secrecy are common and harmful. Participants widely expressed their belief that the social shame and secrecy that surrounds abuse and neglect is very harmful to survivors. One participant reflected the sentiment of many (n = 64): "This is systemic, we don't talk about it—and the fact that we don't talk about it fosters the idea that maybe you were responsible for what happened." Another survivor stated: "We don't discuss these things, it's rude. It is damaging to the psyche and the soul, though even more so because it's invisible." Three additional participants stated:

- "People try to hide it; it [abuse and trauma] makes you feel so alone and ashamed."
- "It would be helpful if someone actually reaches out and initiates the conversation—just kind of allow a space for a discussion about it."
- "Trauma is associated with shame; we need to dismantle shame. If we weren't ashamed [of what happened to us], then we wouldn't worry about being judged, because there'd be nothing to be ashamed about."

Quality of attitudes can affect healing. Participants urged family, friends, and community members to embrace supportive attitudes toward survivors and in support of healing. Overwhelmingly, participants expressed the importance of knowing that survivors are not to blame for the abuse. One participant captured the sentiment of many (n = 114): "It's not the survivor's fault. I am still a lovable person, not to be shunned." Finally, many (n = 210) participants advocated for prohealing attitudes; that is, that healing is possible, particularly with proper support: "[Understand that] People are strong,

and can survive with the appropriate support. It does take time, but it is possible to heal. You can heal from it."

Question 2: Type of support necessary to help survivors of trauma

Participants were asked to describe the types of support they believe are important to help survivors of trauma.

The need for supportive and informed family, friends, and community members. Participants overwhelmingly mentioned the importance of having supportive family and friends. They urged community members to initiate conversations, to reach out to survivors, and to work toward eliminating the isolation that currently so often accompanies abuse and trauma:

- "Family, friends and acquaintances should know that it is natural to feel bad; to show compassion instead of saying, 'Just get over it.'"
- "I just needed someone to be there who would understand what I'd gone through. It could be friends, relatives, or church people. We all need some kind of support."

Access to supportive and informed professionals and services. Many participants (n = 40) highlighted the importance of getting help from sensitive and competent "professionals" who have trauma-specific knowledge: "I think support groups for that kind of trauma, and accessibility to professionals that deal specifically with trauma and violence." In addition to well-trained, trauma-specific providers, several participants (n = 32) expressed a need for a "supportive system" that is readily available:

> You've got to have a system in place because it doesn't seem like any one person can cover it all … a multifaceted, multidisciplinary approach, including physical but certainly psychological and spiritual support. And, it's important to have constantly available reassurance, including a network where you can fall back any time of the day.

Connection with and support from other survivors. When asked what kind of support is important for healing, many participants extended their response to who they believe is central in their healing. As mentioned, this included family and friends. In addition, many participants (n = 65) indicated that it is important for survivors of abuse to connect with other survivors as part of the healing process. Participants believed that acceptance and nonjudgmental responses are more likely from people who have had similar traumatic experiences: "People who went through the same trauma, just supporting each other because I think they know more. There's more of an acceptance there." Moreover, several participants emphasized the

importance of connecting with survivors who have healed or are actively involved in the healing process: "Having other people who have suffered from the same trauma and who have healed from it is so important. Unless you've been through it, it's hard to understand."

Listening and the quality of listening are important. Participants routinely emphasized the importance of being understood, basic acknowledgment of their trauma, and attentive listening. In particular, participants highlighted the importance of listening with compassion, listening to understand, listening to validate, listening with an open mind, and listening without judgment. The following comment from a participant captured the sentiment of many (n = 102): "[It is important] to really sit down and listen and understand … and to have a chance to express my feelings without feeling ridiculed or embarrassed." Others described the importance of listening with compassion, patience, and with few or no intrusions: "[I/We need] patience. Let me talk it out. Don't comment, don't give me your opinion; it has nothing to do with the person listening, but with the person going through it … listen instead of jumping to conclusions." Participants also often (n = 49) indicated that listening in a manner that acknowledged and validated their experience was an instrumental part of the healing process:

- "Someone listening intently, who acknowledges your feelings as okay. To just be listened to in a way that doesn't diminish my experience."
- "Listen in a way that acknowledges and validates that these things happen to people."
- "I just think [support is] having someone around who acknowledges and understands my pain and what happened to me."

Discussion

Many survivor participants (67%) indicated that they were never or rarely helped when they were first abused. As suggested by our qualitative findings, silence and minimization were likely compounded by the sense that, should they disclose—or when they have—participants were often not believed ("Please believe me") and experienced or anticipated shame ("We need to dismantle shame"). This is consistent with Herman's (1997) depiction of the denial and minimization process often associated with trauma and that occurs interpersonally and as a community norm.

Qualitative and quantitative findings in this study also suggest that participants were most likely to first and most often reach out to family and friends for support. Participants believed people in their lives, ostensibly people with whom they are well acquainted, were more equipped to help them heal relative to the

general public, and they indicated that the general public does not have a good overall understanding of trauma and trauma healing. Importantly, when survivors selectively reached out, they were often listened to with compassion. This finding is also consistent with the intimate partner violence universal screening literature where survivors of abuse report that, selectively, they are more likely to share their abuse experiences with health care providers when providers sensitively raise questions about safety, and when they (a) describe their rationale for screening (e.g., "Because I know abuse is common in society, I ask these questions of all of my patients"), (b) proactively share how they will handle disclosures, (c) demonstrate comfort in discussing safety and abuse, and (d) do so without judgment (Maas-Despain & Todahl, 2014; Todahl & Walters, 2011). This also corroborates the well-established belief that people tend to first seek out family and friends for support and guidance, yet do so selectively (Henderson, Evans-Lacko, & Thornicroft, 2013; Sylaska & Edwards, 2014). Finally, this exploratory study adds evidence to the literature of the strong association of receiving support from family and friends and beliefs in have healed and can heal (see Table 5).

Participants had marginal confidence that people in their life know how to help them heal from trauma—only 46% agreed or strongly agreed that family and friends know how to foster healing, and confidence in the general public was much lower; only 19% agreed or strongly agreed. Although survey results revealed low confidence in perceptions of others' help knowledge, qualitative data were rich with participants' suggestions, including listening without judgment, reaching out and initiating a conversation about trauma, and listening to understand. Participants also highlighted the importance of peer support; that is, "having other people who have suffered from the same trauma and who have healed from it." This finding is consistent with calls for community-based solutions (Daro, 2010), trauma training for family and friends (Cortez et al., 2011), and a trauma-informed public (Bloom, 2013).

Table 5. Logistic regression models predicting "have healed" and "can heal" from trauma.

					95% CI	
	Beta	*SE*	*p* value	OR	LB	UB
Have healed from trauma						
Constant	−0.89	0.89	.310	—	—	—
Number of traumatic experiences	−0.27	0.08	.001	0.76	0.66	0.89
Age at first trauma	0.10	0.13	.460	1.10	0.85	1.42
Perception of trauma support	1.23	0.29	< .001	3.43	1.95	6.04
Can heal from trauma						
Constant	−1.72	1.43	.229	—	—	—
Number of traumatic experiences	−0.18	0.12	.131	0.83	0.66	1.06
Age at first trauma	0.25	0.23	.275	1.29	0.82	2.02
Perception of trauma support	2.03	0.46	< .001	7.58	3.04	18.73

Note: CI = confidence interval; *SE* = standard error; OR = odds ratio; LB = lower bound; UB = upper bound.

When asked about what is important to understand about trauma and the type of support needed to foster healing, both qualitative and quantitative responses identified a significant correlation between listening with compassion and trauma healing. Participants also highlighted the importance of nonjudgmental responses, a belief that trauma is widespread and can happen to anyone, the value of demonstrating openness to trauma conversations, understanding the impact of trauma, and the adoption of a view that healing is possible. These recommendations are remarkably consistent with the 10 principles of trauma-informed services promoted by Elliott and colleagues (2005) and echoed by a rapidly growing body of trauma-informed applications in multiple settings, including, for instance, health care settings (Davies et al., 2015), mental health (Endres, Keller, Wong, & Krahn, 2015), child welfare (Fraser et al., 2014), and schools (Perry & Daniels, 2016).

Research limitations

There are a number of limitations to this study. First, although the Survivor Voices questionnaire was vetted by a trauma-informed research team and was piloted and revised, it has not been normed and its reliability and validity properties are not known. Second, although this study used a randomized sampling strategy, the degree to which findings accurately represent the community at large also is not known. For instance, participation was limited to individuals who have a landline phone. Given the dramatic and ongoing shift from landline phone use in recent years, this study's sample very likely excluded a meaningful portion of eligible participants. This could partially explain the disproportionate age ratio in this sample, relative to the general public. Additionally, many more women than men participated in this study. This disproportionate gender representation could be highly correlated with whom answered the phone. Women answered the phone at rates much higher than men, although among those who declined to participate, men and women were equally represented. Moreover, the survey was provided only in English and given the average age of the sample, the findings might not represent the experiences of survivors who were first abused in more recent years. Given these factors and others, the external validity of this study's findings is unknown.

Research implications

This study points to several areas for further investigation, including in particular research questions related to trauma understanding, trauma healing, and prohealing attitudes and behaviors by family, friends, and community systems. For instance, many participants reported that they had healed or were confident that they could heal. Similar to the growing body of

literature that associates protective factors with lower rates of child abuse and neglect (Browne, 2014), a body of inquiry is needed that investigates the most salient individual (e.g., family and friend support) and population-level factors associated with healing and prohealing norms (Herman, 1997) and their effective and sustained implementation at the community level.

In this study, adult family members, child siblings, child friends, and adult nonfamily members were the people most likely to try to help or protect participants who received support when they first experienced violence or abuse. However, nearly 50% of participants reported receiving no help or protection at that time. What must occur among family and friends, for instance, to ensure that abuse survivors are receiving the support they need at or near the time of their traumatic experiences? Research needs to more fully examine the core competencies needed for family and friends to support trauma survivors, to be accessible when most needed, and the systems needed in communities to provide trauma-informed support throughout the social services network. This might include investigations that examine (a) the conditions needed to ensure help is available and sought; (b) family and friend skills to foster healing support among natural systems; and (c) access to scalable trainings that equip community systems and community members to respond in an understanding and affirming way with trauma survivors (Bloom & Reichert, 1998).

Although this study points to several areas for further inquiry about survivor-informed trauma and trauma healing, in our view who is included on trauma healing research teams is at least as important as what is investigated (Wallerstein & Duran, 2006, 2010). In this regard, we believe that survivors of abuse should be directly involved in shaping trauma-informed research questions, design, implementation, and data interpretation and dissemination. This study provides examples of the benefits of participatory methodology (Campbell, Patterson, Adams, Diegel, & Coats, 2008); survivors of trauma were instrumental in decision making at all levels of the development of this study and, due to this involvement, the initial focus of the study shifted from trauma to trauma healing, individual and collective response, and survivor recommendations for what is most helpful for trauma healing.

Implications for practice

The findings of this study are important not only because they validate and increase the knowledge base related to trauma and healing, but also because they clarify the need for and direction of future action. The wisdom of survivors reflected here provides guidance to anyone interested in promoting health and well-being for individual trauma survivors, for their families and communities, and for the professionals and organizations that care for them. This section highlights implications for (a) engaging survivors as leaders in

any effort to address their needs, (b) ensuring lay community members and professionals are able and willing to provide thoughtful and effective (trauma-informed) support to survivors, and (c) increasing the availability and utilization of trauma-healing (trauma-specific) resources and services.

Survivor leadership and engagement

Emerging definitions of trauma-informed care (Bloom, 2013; Heffernan & Viggiani, 2015) promote the direct engagement of survivor-consumers in the development, implementation, and evaluation of responses, and interventions and programs designed to help them recover. Our research suggests that survivor insight is vitally important for any effort to promote healing and wellness for individuals and communities after trauma, and that it has very often been ignored or dismissed. Fortunately, survivors not only want to share their wisdom, but many also find it personally beneficial to do so (Cortez et al., 2011).

There are many practical challenges that must be addressed to engage rather than tokenize survivors. Professionals with histories of trauma face the risk of stigma or discrimination for being open about their experiences. Changing this reality will require the intentional creation of environments (e.g., social service, school, and health care settings) that encourage and support survivors to engage as survivors. This includes the important step of engaging survivors as leaders due, in part, to their (our) trauma-informed expertise.

Trauma-informed community, professionals, and organizations

Survivors on our research team and in our study highlighted very clear requirements for being trauma-informed: compassion, understanding, and knowledge. Specifically, survivors want friends, family, and professionals to listen with compassion, understand the impact of trauma on their lives, and know how to help. They also know what they do not want—judgment, blame, coercion, labels, or misinformation. Given the prevalence of trauma in our communities and its impact on so many people, it makes sense that there would be confusion and difficulty with the topic. At the same time, our experience with this study shows that when survivors are given the opportunity and feel safe enough, they want to talk about their experiences and share their wisdom about coping and healing. It is vital, therefore, that trauma-informed care development and practice are led by and meaningfully incorporate survivors' perspectives (Burstow, 2005).

Trauma-specific resources

This study suggests that the definition of what counts as trauma-specific should include community-based, traditional, and complementary resources and practices in addition to clinical treatments and interventions (van der Kolk, 2014). Survivors identified many types of resources and services they think should be available to support and promote healing after trauma. In addition to more conventional mental health services, these included

specialized support groups, knowledgeable peers, expressive arts, and many forms of body work. As such, given their unique understanding of the terrain of trauma and healing, survivors can unearth healing systems and strategies that they are already using; work to illuminate and perpetuate them; and lead the effort to ensure that family, friends, and systems provide the support and conditions to support trauma healing and to prevent its occurrence.

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