CHAPTER 7

Understanding Context, Coping, and Impact:

Gender-Based Violence and Substance Use

7.

Understanding Context, Coping, and Impact: Gender-Based Violence and Substance Use

7.1 WHY A RELATIONAL, STRENGTHS-BASED LENS?

Women's experiences of GBV and substance use are situated—shaped by relationships, safety, caregiving, community, and structural forces. A relational, trust-building approach begins with privacy, invitation, and pace-setting by the woman. It is not an add-on to clinical technique; it is the condition that makes care safer, more equitable, and more useful (EQUIP Health Care and GTV Incubator, 2024; Centre of Excellence for Women's Health, 2017).

When we meet someone navigating substance use and gender-based violence (GBV), we begin with a relationship. A strengths-based, relational approach treats trust as the first intervention. We offer privacy and predictability, ask permission before discussing sensitive topics, and move at the person's pace. We listen for what is hard and for what is holding her together—protective actions, caregiving, creativity, and resistance.

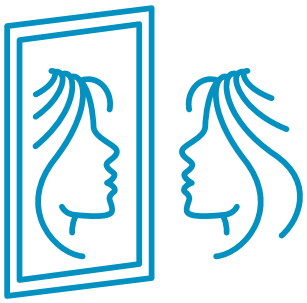
Throughout this chapter, we weave EQUIP's Trauma- and Violence-Informed Care (TVIC) principles into four anchors to guide and support relational, trust-building approaches:

WHAT THIS LOOKS LIKE IN PRACTICE:

Begin with curiosity and consent:

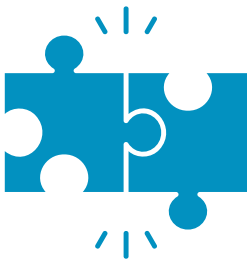
"We ask everyone about safety and health, including substance use. Would it be okay to talk about what matters most to you today?"

Explain your role and any limits, then invite the person to guide the focus



Reflect the strengths and protective actions you hear.

Match support to what is needed now, not to a predetermined pathway.



(Centre of Excellence for Women's Health, 2017).

7.2 HOW EXPERIENCES OF SUBSTANCE USE AND GBV MAY SHOW UP: POTENTIAL SIGNS TO GUIDE CARE WORKERS SUPPORTING WOMEN

WHAT TO KEEP IN MIND...

Experiences of GBV and substance use are diverse, contextual, and culturally situated.

Signs vary across individuals and circumstances. The goal is not to diagnose or label.

The goal is to notice patterns, invite consent led conversation, and offer practical support.

The lists below are examples (not a checklist) to help care workers listen for meaning, safety needs, and small next steps.

LISTEN FOR PATTERNS AND MEANINGS

- Coping that helps in one area but costs in another (e.g., substance use supports sleep yet strains housing or relationships).
- Boundary pushing or control framed as “care” (e.g., controlling medications, transport, phone).
- Transitions that increase risk (moves, pregnancy/post-partum, court dates, separation, new treatment).

HOW EXPERIENCES MAY SHOW UP IN EVERYDAY LIFE

Listen for patterns and meanings in daily life: contextual coping; boundary-pushing or control; psychological/emotional harms; and periods of increased risk during transitions.

(EQUIP Health Care & GTV Incubator, 2024)

PSYCHOLOGICAL & EMOTIONAL

How experiences may show up psychologically & emotionally:

- Heightened anxiety, hypervigilance, irritability, or feeling "on edge."
- Emotional numbing, flattened affect, or sudden mood shifts tied to safety cues.
- Guilt, shame, or self-blame after incidents or when coping involves substance use.
- Intrusions (nightmares, flashbacks) or difficulty staying present during stressful moments.
- Grief and loss (relationships, children, housing, community, identity).

(EQUIP Health Care & GTV Incubator, 2024)

SOCIAL AND RELATIONAL

HOW EXPERIENCES MAY SHOW UP SOCIALLY & RELATIONALLY:

- Isolation from family/friends; restricted contact or supervised calls.
- A partner/other monitors movements or communications; insists on speaking for her.
- Financial control (withholding money/ID), reproductive control (pregnancy pressure, birth control sabotage), or co-parenting threats.
- Needing to stay with a partner due to the risk of losing housing, income, transportation, or protection from others.
- Peer networks that feel safer than formal services, especially when stigma is high.

(EQUIP Health Care & GTV Incubator, 2024)

HOW EXPERIENCES MAY SHOW UP IN HEALTH/MEDICAL NEEDS:

- Sleep disturbance, chronic pain, headaches, stomach/digestive concerns, or diffuse somatic/physical symptoms.
- Medication interference (missing doses; someone controlling storage/administration).
- Interrupted care (missed appointments when privacy or transport is constrained).
- Pregnancy-related stressors (fear of child welfare involvement; limited prenatal continuity).
- Overdose risk or drug toxicity concerns (especially after periods of reduced use).
- Intoxication-related health risks (alcohol induced falls, liver effects, pancreatitis).

(EQUIP Health Care & GTV Incubator, 2024)

Traumatic brain injuries (TBI) resulting from being hit in the head, strangulation, or other injuries can lead to repeated TBIs that are often under-recognized and misdiagnosed. The impacts of TBI can affect memory, mood regulation, cognition, behaviour, and engagement with services. Sessions may need to be modified. Referrals and connections to services that support TBI assessment and intervention through primary care providers and specialists may be needed to help clients access the TBI resources and services they require.

HOW EXPERIENCES MAY SHOW UP BEHAVIOURALLY:

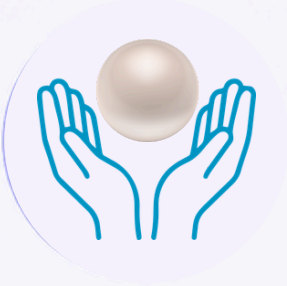
- Changes in substance use – use patterns (frequency, type, route), spikes after violence, or pressured/coerced use.
- Avoidance of certain questions, places, or people that cue danger.
- Missed or last-minute rescheduled visits when surveillance is high or transport is controlled.
- Risk-taking or sudden withdrawal from usual activities following a destabilizing event.

HOW EXPERIENCES MAY SHOW UP IN THE BODY/PHYSICALLY:

- Head/neck injuries, bruises, or patterned injuries with explanations that don't fit.
- Signs consistent with strangulation (voice changes, swallowing pain, headaches, dizziness).
- Reproductive injuries or frequent UTIs/STIs; contraceptive failures tied to control.
- Neglected dental or wound care when access is unsafe or restricted.

NOT EVERY SIGN/IMPACT IS VISIBLE

When GBV and substance use intersect, warning signs may appear as inconsistent stories, missed appointments, or remaining with a partner because housing or transportation is tied to that relationship. Treat these as context, not "non-compliance."



Practice Pearl: Barriers to Recognition

Many women normalize trauma responses or avoid disclosure because of stigma, fear of judgment, immigration or legal concerns, or distrust of systems. A predictable process, clear roles and limits, and choice at every step help build safety, allowing women to share only what is needed today.

Some ways to ask about GBV and substance use:

- "We ask everyone about safety and health, including substance use.
- "Would it be okay to talk about what feels most important to you today?"
- "I'm not here to put labels on your substance use or your relationship. I'm here to notice patterns with you and explore how they've been impacting you."
- "Sometimes partners pressure or control substance use or medications. Has anything like that been happening for you?"
- "Many people use substances to cope with stress or past experiences. Which of these options feels doable and supportive?"

Psychological & Emotional
Anxiety, hypervigilance, emotional numbing, guilt/shame, and intrusive memories.

Social & Relational
Isolation; control over phone, transportation, or medications; financial or reproductive control.

Health/ Medical
Sleep disturbances, chronic pain, gastrointestinal complaints, and interrupted care.

Physical
Head and neck injuries, visible signs of injury, reproductive injuries, and wounds or dental injuries.

Behavioural
Shifts in substance use patterns; coerced use; increased use after violence; avoidance.

Environmental & Systemic
Lack of safe access to a phone, transportation, or identification; housing precarity; court or legal stress; child welfare fears; and experiences of racism or colonial harms.

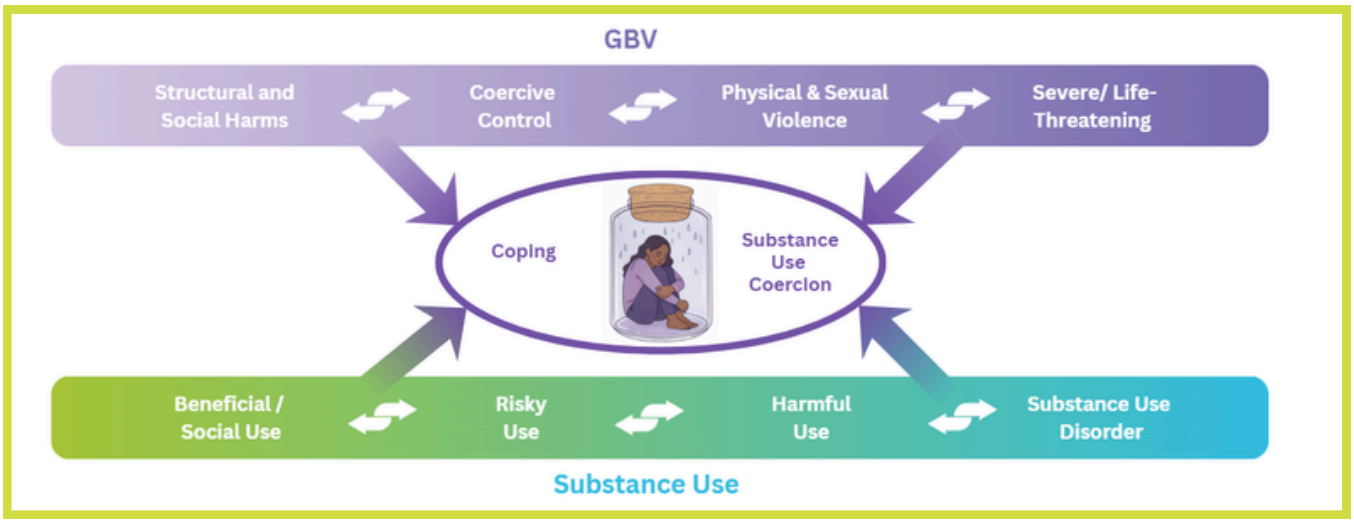
Documentation Nudge (for Staff)

Use neutral, non-stigmatizing language. Capture patterns (e.g., control over medications or transportation; pressured or coerced use; escalation around court dates), protective actions, and what matters most to her. Confirm who can access records and plan for safe communication. Document strengths and safety planning, as well as goals and strategies that support success.

7.3. USING THE DUAL-CONTINUUM LENS

Women may be at different points across the Substance-Use Continuum and the GBV Spectrum over time. Mapping both helps name what is happening without blame or labels and supports choosing a small, doable micro-step together.

Pause to notice what the substance is helping with, where it gets in the way, and what "safer" would look like this week.



How the Two Lenses Work Together (in Practice)

Rather than scoring or labelling, we gently map the woman's experience across both lenses (GBV and substance use). On the substance-use side, that might mean noticing whether use has been social, episodic, risky, harmful, or overwhelming and asking what each pattern has been helping with and hindering, including impacts on health and wellness. On the GBV side, we listen for boundary-pushing, coercive control, psychological harm, and any signs of physical or sexual violence, remembering that risks can rise during separation and transitions.

Substance-use coercion bridges the two lenses: partners may control or divert medications, pressure someone to use, sabotage care, or threaten consequences around treatment. Naming these patterns without judgment often brings relief—many people have never had this link acknowledged out loud.

SEEING OVERLAYS (EXAMPLES TO NOTICE)

- Episodic use + boundary violations → validate coping and explore situational safety (timing, setting, transportation).

- Risky use + coercive control → explore substance-use coercion; plan safer use, medication storage/privacy, and supervised dosing options if relevant.

- Harmful use + psychological abuse → provide first-line support (LIVES), harm-reduction strategies, warm transfers, and peer accompaniment

- Feeling stuck (SUD) + severe violence → support high-risk safety planning, integrated gender- and trauma-informed pathways, privacy protections, and careful documentation of patterns.

RELATIONAL LANGUAGE TO TRY (MI-ALIGNED)

- “What feels most important to talk about today?”
- “What does [substance] help with most? Where is it getting in the way?”
- “Sometimes partners set rules about medications or use. Has anything like that shown up for you?”
- “Of the ideas we discussed, which (if any) feel like they fit this week?”
- “You’ve been doing a lot to get through this. What would a little more safety or steadiness look like right now?”

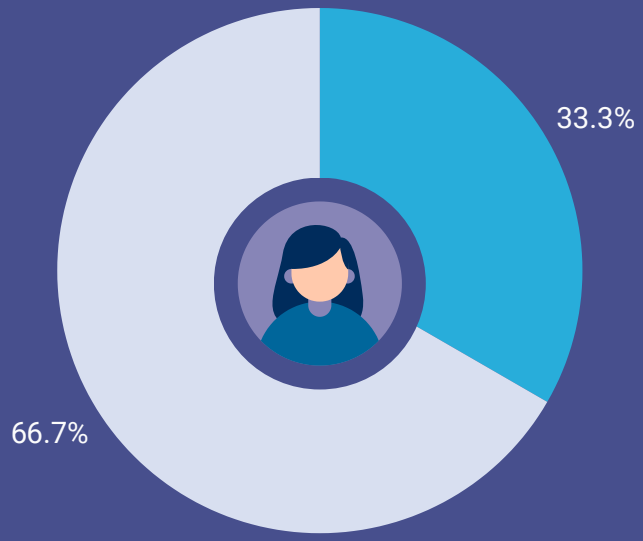
Why This Matters

Trust is the intervention. In a steady relationship—one that sees both the inner logic of substance use and the many faces of violence—small choices add up. People move across continuums; our role is to walk alongside, keep doors open, and make the next step easier to take.

DID YOU KNOW?

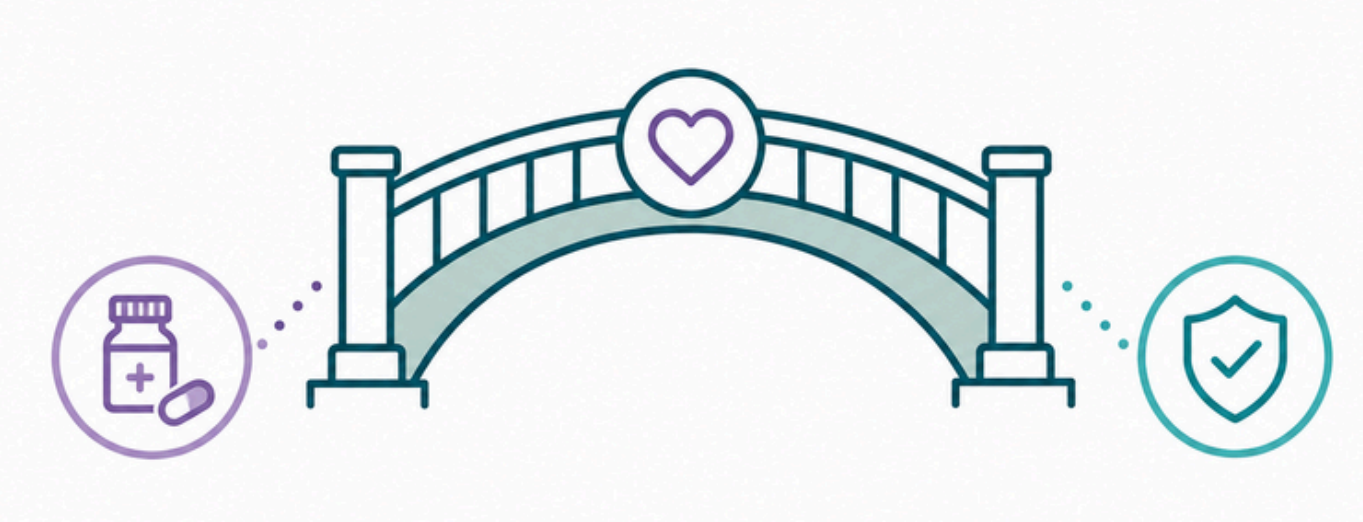
According to the World Health Organization (WHO), “1 in 3 women globally experience gender-based violence” (2021). Considering this widespread prevalence, routinely asking women about GBV during routine processes of care—from initial screening through regular, repeated screening during subsequent contacts—is necessary to enable timely support and access to services.

Asking About GBV Routinely From First Contact and Throughout Service Engagement



7.4. SUBSTANCE-USE COERCION (A BRIDGE BETWEEN LENSES)

Sometimes partners control medications, pressure someone to use substances, sabotage care, or leverage disclosure to punish. Naming substance-use coercion without judgment supports collaborative safety planning—such as medication privacy, safer-use options, and supervised dosing if desired—as well as consent-based warm transfers.



Practice Takeaway

Normalize, Don't Pathologize
Name substance use as a coping response and emphasize choice and safety.

Language to Try: **"Sometimes partners set rules about medications or substance use. Has anything like that shown up for you? If so, what would feel safer this week?"**

Practice Takeaway

Flag Possible TBI/Strangulation
Ask about head or neck pressure, loss of consciousness, memory gaps, and changes in voice or swallowing.

Adapt session length, provide written summaries, and consider referral.

Myth Buster: Misconceptions about “BPD”

MYTH: “People with Borderline Personality Disorder (BPD)” are attention-seeking, manipulative, or have multiple personalities.

FACT: Research shows that people with BPD experience emotions more intensely and for longer durations; behaviours often misinterpreted as attention-seeking are driven by distress, not intention (Navarre, 2025). What looks like “attention-seeking” is usually connection-seeking or the nervous system trying to feel safe after a perceived threat or abandonment (Navarre, 2025).

According to the DSM-5-TR, Borderline Personality Disorder (BPD) is a diagnosed condition characterized by a “pervasive pattern of instability in interpersonal relationships, self-image, and affects, along with marked impulsivity, beginning by early adulthood and present in a variety of contexts” (American Psychiatric Association [APA], 2022). The diagnosis requires that specific diagnostic criteria be met and must be made by a qualified health professional authorized to assess and diagnose the condition. Often, people diagnosed with borderline personality disorder have histories of multiple and complex traumas.

7.5. RESPONDING TO HOW THE IMPACTS OF GBV AND SUBSTANCE USE SHOW UP FOR WOMEN

Women experiencing gender-based violence (GBV) and substance use face compounded vulnerabilities, requiring integrated, trauma-informed, and gender-responsive approaches. Research and global guidelines emphasize the following best practices:

A.

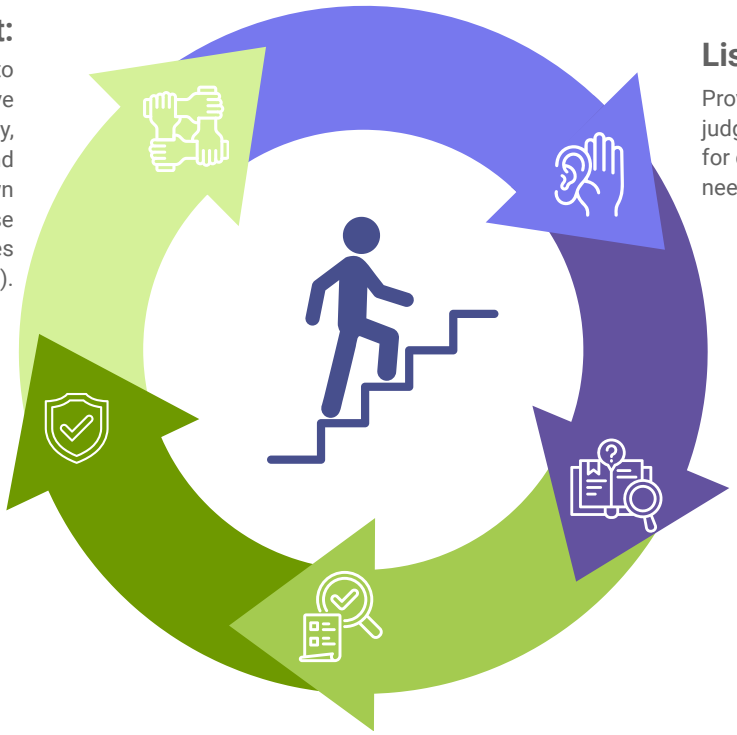
APPLY TRAUMA-INFORMED AND SURVIVOR-CENTRED CARE

Ensure safety, trust, and empowerment in all interactions. (SAMHSA, 2014)

Avoid re-traumatization by using non-judgmental, empathetic communication and respecting autonomy. (WHO, 2013)

B. PRACTICAL STEPS: LIVES

Support:
Provide warm referrals to integrated, gender-responsive services (e.g., Seeking Safety, Helping Women Recover, and TREM) that have been shown to improve both substance use and trauma outcomes (Johnstone et al., 2023).



Listen:
Provide an empathetic, non-judgmental space; avoid pressing for details beyond clinical safety needs (WHO, 2013).

Enhance safety:
Develop safety and harm-reduction plans (e.g., overdose prevention and safer-use strategies) and document threats such as strangulation (Moir et al., 2022; WHO, 2013).

Inquire:
Assess immediate safety, health, and substance-related risks; explore coercion, withdrawal risks, and child safety concerns (WHO, 2013; UNODC, 2023).

Validate:
Affirm that the violence is not the survivor's fault; acknowledge trauma and substance use as coping responses (WHO, 2013).

C. SCREENING, DOCUMENTATION, AND COLLABORATION:

- Screen for GBV and substance use **together** in confidential settings (WHO, 2013).
- Use validated tools and ensure culturally sensitive practices (Johnstone et al., 2023).
- Provide warm referrals—helping individuals connect with another service or program through service navigation and more hands-on support than providing information alone—to trauma-informed substance use disorder treatment programs such as Seeking Safety and Helping Women Recover (Najavits, 2015).
- Prioritize survivor choice and map local referral pathways (WHO, 2013).
- Coordinate with harm-reduction services, substance use services, legal and advocacy services, and child protection systems, recognizing the unique barriers faced by women who use drugs (UNODC, 2023; Romo-Avilés et al., 2024).

Details on screening are summarized in Chapter 10 of this toolkit.

D. INTEGRATED CASE MANAGEMENT AND COUNSELLING

- Often, women experiencing GBV and substance use require both case management support and counselling.
- Programs should offer integrated case management and counselling supports. When this is not possible, coordinated access to both services should be facilitated.

E. MULTISECTORAL COLLABORATION

- Coordinate with health, legal, housing, and social services to address complex needs.
- Build referral networks for mental health, substance use, and GBV advocacy services (Centers for Disease Control and Prevention [CDC], 2016).

F. ADDRESS STRUCTURAL BARRIERS

- Reduce stigma and discrimination in service delivery.
- Advocate for policies that integrate GBV and substance use services and supports, while also providing economic and housing support.
- Use trauma-informed, gender-responsive screening for both GBV and substance use.
- Provide integrated care models such as Seeking Safety or Helping Women Recover, which address trauma and substance use concurrently (Johnstone et al., 2023).

What is Harm Reduction?

Harm reduction is an evidence-supported, person-focused approach designed to lessen the health, social, and legal risks and harms linked to substance use without requiring people to stop using substances. In Canada, this approach emphasizes dignity, personal choice, and the active participation of people who use substances.

The focus is on supporting people who use substances where they are at, while promoting safety and minimizing substance-related harms in ways that align with the person's choices, wishes, and goals for their own recovery journey.

Practice Pearl:
A five-step relational conversation (about 3–5 minutes)

1) Prepare & Invite — Privacy check, role/limits, universal framing (“we ask everyone…”)

2) Map Meaning — What is the substance helping with? Where is it getting in the way? Notice boundary erosion or control.

3) Co-create One Micro-Step — A safety adjustment, grounding practice, peer contact, or shorter follow-up—chosen by her.

4) Plan for Safety & Documentation —Capture patterns (e.g., interference with medications) in neutral language; confirm who can access notes; consider safety risks and harm-reduction choices.

5) Close With Choice & Predictability — Offer options (including waiting), agree on next contact, and keep doors open.