Chapter Three
The Effects of Trauma
In Women's Lives

New Partnerships for Women

The Effects of Trauma on Women's Mental Health and Substance Use

There are many theories linking trauma and mental health or substance use problems among women. They differ in a number of important ways that shape what we know about the effects of trauma in women's lives. One difference among theories is in whether they are focused on short-term reactions to trauma, or reactions occurring over a longer period of time. Another difference is in the pathway or pathways they view as important in understanding the trauma-mental health link.

In this chapter, we begin by reviewing a prominent theory of the immediate, or short-term, effects of trauma exposure on men and women's lives, which assumes that most people recover in the short-term from such exposures, although some go on to develop more long-lasting mental health problems. We then share the stories of several women for whom traumatic experiences are longer lasting and ask, what is it about their lives and experiences that made it difficult for them to recover in the short-term? Drawing on these stories, along with findings from community studies of trauma exposure and consequences, we develop a general theory of the pathways through which exposure to traumatic life events may lead to a mental health or substance use problem, or both. We also consider some of the resources and strengths of women that help them prevail in the face of great adversity.

Short-term effects of trauma in women's lives:

As Edna Foa and her colleagues (2006) note in *Common Reactions to Trauma*, exposure to traumatic life events or experiences may cause many emotional problems in the short term. In fact, many of these changes following a trauma are normal and most people who experience a major life trauma have severe problems in the immediate aftermath. Here we highlight some of the more common problems adults experience in the wake of a traumatic life event, which are described in more detail at the website for the National Center for post traumatic stress disorder (PTSD) (see reference for site).

Suggested Reading:

- *Common Reactions to Trauma* by Edna B. Foa, Elizabeth A. Hembree, David Riggs, Sheila Rauch, and Martin Franklin (2006)

- *Fear and anxiety* are common and natural responses to a dangerous situation and may continue, if not recur long after the trauma has occurred, sometimes being triggered by places, times of day, smells or noises, or other situations that remind you of the trauma.
- *Re-experiencing the trauma* through unwanted thoughts, flashbacks, or vivid images are also common.
- *Increased arousal* is another common response to trauma, which may be accompanied by feeling jumpy, jittery, shaky or irritable. Such arousal reactions are due to the fight or flight response in our bodies in the face of danger—we, like animals, protect ourselves from danger by fighting or running

away. This requires more energy than usual so our bodies pump out extra adrenaline to help us get the extra energy we need to survive. Over long periods of time, such states of arousal and vigilance can be very uncomfortable. Another variation of this state is *freezing*, much like a deer caught in the headlights.

- *Avoidance* is another common response to managing trauma-related pain. We may avoid situations associated with the trauma or even push away painful thoughts and feelings resulting in *numbness* or the deadening of any feelings.
- *Anger or irritability* commonly follow traumatic experiences and can be extremely uncomfortable, especially if experienced on the spur of the moment in relation to people you are close to.
- *Guilt and shame* may also follow exposure to traumatic life events, particularly if one feels somehow to blame for what happened or is made to feel that way by others.
- *Grief and depression* are also common reactions to trauma and can include feelings of hopelessness and despair, sadness, and crying, or feeling that life is not worth living.
- *A negative self-image or view of the world* can also develop following a traumatic life experience. You may decide "I am a bad person and deserved this." Alternatively, you may conclude that you can't trust anyone or anything. Both feelings can co-exist and are often part of the package of guilt, shame, grief, and depression.
- *Sexual relationships* may also suffer after a traumatic experience. For many, a loss of interest in sex is common, particularly if the trauma involves a sexual assault.
- *Increased use of alcohol or other substances* is also not uncommon in the wake of a traumatic event.

Foa and her associates note (2006) that it is not unusual for a number of these reactions to occur in combination following exposure to a traumatic life experience. However, for many people, such thoughts, feelings, and behaviors typically diminish, or completely disappear, over a two to three month period following exposure to a traumatic life experience. Others recover more slowly while some may have recurring problems for years following the trauma. **An important question is what makes the difference between those who do and those who do not recover in the short term?** And what are the factors that protect against the development of mental health or substance abuse problems in the wake of exposure to traumatic life events, particularly events involving physical and or sexual abuse? To address these questions, we turn first to women's stories.

Listening to women's stories

In the course of our earlier study and our community work and trainings, we have invited women to give accounts of major life traumas they have experienced. We have also invited them to tell us about the impact of such events on their lives in the short term, as well as over time. Finally, we inquired into their own recovery process, asking what they found helpful or harmful in coping with these traumas and

their emotional consequences. We share some of these stories below using pseudonyms to protect our story tellers' identities. We begin with Y'kana's story:

> I was molested by my friend's father when I was 14. This molestation went on for 3 ½ years. One time he tried to take my virginity, but I was too small to enter. The last time, when he was going to try again, I shook my head 'no.' A month later; he was dead during an operation. I was 17 and went to the wake for my friend's sake.

Initially, Y'kana reacted with a range of feelings, emotions and physical revulsion: "My immediate response, besides shame, guilt, worry, was to become physically ill, nauseous. When I went home, I stayed isolated in my room for two days, not even coming out for meals." Over time, Y'kana's feelings changed to hate, anger, and more guilt: "I had a choice—stay home and get hit or terribly ridiculed or seek refuge at my best friend's house, though it meant getting sexually abused. Since what he did didn't hurt like getting hit (except the one time he tried to take my virginity), it was like the lesser of two evils. I guess it did hurt emotionally in that my curiosity made me feel very guilty." Now 45 years old, Y'kana reflects on the help she received from her therapist and from reading the book, *Courage to Heal*. She also reminds herself, "He's been a skeleton in a box in the ground for almost 30 years now. I remind myself that my body responding doesn't make me sinful or bad."

Although Y'kana feels she has made much progress in her recovery from this difficult stretch in her adolescent years, she notes that she still has a lot of problems with sex and intimacy. Her friend, with whom she still has contact, has similar problems and she wonders: "I still suspect that he also sexually abused my best friend, but I don't want to trigger her trauma by asking her or telling her what he did (to me)."

Mary's story is in some ways similar to Y'kana's, although she relates a series of traumatic life events: (1) rape at 13, (2) parental physical abuse (which started most of her problems, she says); (3) divorce due to husband's ongoing infidelity, and (4) physically abusive relationship. She recounts that the physical abuse by her parents lasted for years and went as far back as she could remember. "I felt unwanted and unloved—I ran away from home numerous times as a teen. Bruises were noticed by my best friend. I couldn't leave the home as I had to protect my brother." Over time, Mary's feelings changed to rebellion although she suffered from low self-esteem. She notes: "I was afraid to be a parent fearing I would continue the cycle." With the help of "lots of counseling," in addition to "having friends who understand," Mary has made good progress in her recovery. Now at age 56 she notes: "I am bi-polar and suffer from depression, but I am not suicidal any more."

Although Mary has little to say about the impact of her marital problems and abuse on her current well being, Tries to Catch Moonbeams With a Net, as she refers to herself, focused primarily on her relationship abuse. It began when she was 32 years old. We refer to her subsequently as Moonbeams. She tells us: "My traumatic event(s) lasted years and began when my ex-partner escalated her emotional abuse of me by using the police to have me, or threaten to have me, placed in the psych unit." She notes that the police did not believe her side of the story "because I had a mental

illness." One time, when she sustained a head injury during an argument and had to be taken to the ER, "even the ER doctor believed her [ex-partner's] version of the event." "I had no allies—I felt trapped, alone, and with no way out."

Moonbeams described her reactions to these relationship abuses as a difficult dilemma: "Mostly I was confused and I self-blamed a lot. I thought my illness was to blame. If only I wasn't 'crazy' this wouldn't be happening to me. I feared the police (I lived in a town of about 2,000 people) and felt watched. The police would sometimes stop and ask me how I was doing and if my medication was working for me. I was afraid to go out and afraid to stay home. I am still leery of police and ER situations."

Over time, her feelings and emotions grew more intense. "I began to self-injure and withdraw. I attempted suicide several times. When a therapist finally believed me, I began to feel better. I am still left with nightmares and I live alone—unsure that I can trust another to be intimate with." Despite these residual problems, Moonbeams feels there are ways in which she has recovered. "I no longer blame myself. I do/am able to get out and trust enough to have friends. I no longer injure myself—I am able to pursue my career and my creativity and my religion, which was denied to me because my partner saw Native Earth-based religions as pagan." Moonbeams concludes that what has been most helpful is: "Having a person who believed in me—and a new circle of women—most of whom have been affected by abuse and trauma. We have created our own community that is supportive and accepting."

Truth, now 26 years old, attributes her personal recovery to her religious faith, although much of her childhood and adolescence was spent in an abusive home: "I was raised in an abusive family for 18 years. My father emotionally, physically, and sexually abused my mother, brother, and me. In 1997, he beat the family dogs to death and was sent to prison. He was a teacher in my high school, so I was humiliated the day I went to school while my father's face was being broadcasted across the ---- area."

Truth's initial reactions were anger, depression, and anxiety, especially during college. "I was hospitalized in a psychiatric ward twice during that time for traumatic flashbacks and self-mutilation. I struggled with alcohol/drug addiction, eating disorders, and became promiscuous. I have worked with three different therapists since 1997." Truth has since had a remarkable recovery. She notes: "I am healed! In recovery→completely. No psychotropic meds, no addiction, healthy body, and good interpersonal relationships. I will be terminating my clinical relationships with my therapist and psychiatrist soon." Hopeful of soon completing her master's degree in clinical work, eventually marrying and having children, Truth believes that "Accepting Christ into my life" has been the most helpful thing in her recovery process. "The therapy, medication, education all helped, but God put all of these avenues into my life to help me find Him. In the Lord, miracles are a reality."

Lucy's story, which, like Truth's, involved early family violence, focuses upon the role of witness, rather than victim. "As a young girl, I witnessed my father beat my mother up, call her names, etc. He also abused animals." These experiences,

which lasted for about 2 years from the time she was 9 or 10 years old, led to a number of personal problems for Lucy. "I have experienced post traumatic stress disorder, extreme startle response, depression, not knowing how to handle many situations, no ability to handle any conflict in my life, highly sensitive to yelling, flashbacks, aggressive behavior, abuse of drugs and alcohol. Feelings could include guilt, shame, fear, loneliness, lack of trust in males, and anger. It has made me highly independent, not having to rely on anyone to meet any of my needs."

Lucy, now 43, sees her own recovery as aided by the counseling she received. "With counseling I have been able to accept what occurred in my childhood and learn from it. As I get older, I tend to be able to tolerate more of other people's behavior. Strained relationships with (my) parents have healed. I am now able to use them to my advantage rather than them hindering my progress. I don't feel that the feelings have necessarily gone away, but the behaviors have changed. I think just time and forgiveness have lessened the feelings, as well as talking about it with both parents. Education has helped with the aggressive behavior, as I became a parent myself."

Lucy describes many ways in which she has recovered from her father's abusiveness. "I am not aggressive at all any more. I can actually talk about it without judgment or crying. I am able to help my younger siblings discuss their feelings about what we experienced. I no longer abuse alcohol. I no longer feel guilt, shame, or anger about the issue. I try to teach my kids how to handle anger appropriately. I don't resent my parents for my childhood trauma any longer. I have healthy relationships with both parents separately. I have set boundaries with my father to ensure my wishes and safety, as well as for my kids."

We conclude with Elizabeth's story—another story of family violence involving the role of witness and victim: "I was with a man for only 2 ½ months. In that time, he brutally beat my two children. Each of them had a broken leg. T. was in the hospital for 10 days with a broken collarbone and bruises on his face from him trying to crush his head. My daughter, R., was sexually abused by him. I also have a third child, which is his because he thought if he got me pregnant, I would never leave him. I also was physically and sexually abused by him."

In recounting her feelings, emotions, and behaviors in response to his abusive behavior, Elizabeth's key emotion was fear: "Fear...when this has never happened to you before and you have never known anyone that has experienced it, you are paralyzed by fear and you don't know what to do. My abuser made sure I was isolated from all my family and friends." Elizabeth and her children were terrorized, she notes, for "2 months and 14 days," at which point she apparently turned to a domestic violence shelter and ended the relationship. Explaining her changed feelings and actions, she noted: "The fear turned to anger and guilt—anger at him for what he did to us and anger at myself for being a fool. Also, I felt guilt that my children suffered so at his hand."

Elizabeth, in looking back at her own recovery process, notes that the most helpful thing she did was to seek out a good counselor who "...taught me how to forgive myself." She has used this experience "to help others out in similar situations." It has also helped her "teach my children a lot about abuse and what it

is." As she continues to learn about healthy relationships through her counseling sessions, she is also actively involved in helping other women recover from domestic violence experiences.

Making Sense of Women's Stories

In the discussion that follows, we are going to use these stories, along with findings from recent community studies, to begin to develop a theory of the long-term impact of trauma on women's lives. We invite you to take a break now from reading and begin to think about these questions in the context of your own life and experiences. When you feel you have the time and interest, and have taken a sufficient break from this difficult material, we ask that you read on.

Making Sense of Women's Stories

Question 1: Looking at the list of common reactions to trauma (Foa et al.), which of the women's initial reactions to the trauma they describe include one or more of these feelings or responses *in the short term?*

Question 2: Are there other short-term reactions in these women's stories that you don't see on this list?

Question 3: Which of the women, if any, recovered completely in the short-term from exposure to their traumatic life situations?

Question 4: What do the women's stories reveal about the long-term consequences of exposure to such life traumas?

Question 5: In what ways do you see signs of hope and recovery in these women's stories?

Question 6: What resources do women find most helpful to them in their recovery process?

Question 7: What lessons, if any, can you take from these women's stories that might be helpful in your own growth and recovery process?

Long-term Effects of Trauma in Women's Lives

The women's stories reviewed above reveal many long-term effects of trauma in women's lives linked with complicated histories of abuse. Their stories weave together themes of physical, sexual, and emotional abuse, and sometimes witnessing the abuse of a parent, sibling, or one's children, or favorite animals. Some are stories of childhood abuse experiences that lasted for years, others are stories of abuse at the hands of one's partner also lasting for years, and, in one instance, a story of abuse at the hands of one's parents and subsequently one's partner. In this chapter, we will focus on some of the pathways through which exposure to histories of physical or sexual abuse, or both, are linked with mental health and substance use problems. We start with a review of studies that have been conducted to investigate the link between childhood adversities, including abuse experiences, and adult mental health outcomes. We then turn to studies of the link between adult victimization experiences and mental health outcomes.

Childhood Victimization and Mental Health/Substance Use Problems

We should note at the outset that not all women who have been exposed to childhood adversities develop mental health or substance use problems in adulthood. In fact, most do not. Thus, it is important to think of exposure to traumatic life events as "increasing the risk" of certain mental health and substance use problems over time. We will first explore which mental health problems are most commonly linked with abuse experiences. Then we will turn to an exploration of pathways and processes through which such increased risk occurs. Finally, we will conclude with a discussion of protective factors that prevent the development of mental health and substance use problems among women exposed to such adversities and discuss their implications for women's recovery efforts.

We begin with two large-scale studies that have attempted to investigate and compare the link between different forms of childhood abuse and adult mental health outcomes. Using data from the NVAW study (Thompson et al., 2002), Thompson and her colleagues showed that both childhood physical abuse and childhood sexual abuse were associated with an increased risk of women reporting a chronic mental health condition that started in adulthood. Women with a history of physical victimization were more than two times as likely as women with no such history to report a chronic mental health condition (2.15) and women with a history of sexual victimization were over 1 and a half times as likely as women with no such history to report a chronic mental health condition (1.77). Both forms of childhood victimization were also linked with an increased risk of drug use in the past month (1.57 for physical victimization and 1.55 for sexual victimization). Finally, physical victimization, but not sexual victimization was associated with a significantly higher risk of using alcohol on a daily basis over the past year (1.41 for physical victimization versus .95 for sexual victimization). Although these findings suggest that childhood physical victimization may have somewhat worse consequences for adult women's mental health and substance use problems than childhood sexual victimization, the authors note that women with the highest risk of adult drug use and a chronic mental health

condition were those who experienced both forms versus one form of childhood victimization.

Similar findings have been reported for the Adverse Childhood Experiences Study (ACE) we discussed earlier. Summarizing findings of a study of over 8600 members of an HMO who completed questionnaires about childhood adversities, Edwards and his associates (2003) found that virtually all forms of childhood adversities were associated with poorer mental health (more symptoms of anxiety and depression). Using a cutoff score on the symptom scale to designate a probable mental disorder, Edwards et al. found that 9.5% of women with no abuse history were positive for a mental disorder compared to 11.9% of women with histories of childhood sexual abuse, 13.7% of women who witnessed maternal battering during childhood, and 17.8% of women with histories of childhood physical abuse. Again, rates were even higher for women with multiple forms of childhood abuse experiences. Twenty percent of women who experienced all three forms of adversity (physical and sexual abuse and witnessing maternal battering during childhood) were positive for a mental disorder; 18.9% of women who experience both physical and sexual abuse were positive for a mental disorder.

The Edwards et al. (2003) study also investigated the impact that emotional abuse had on the risk of adult mental health problems, apart from other forms of childhood victimization experiences. It concluded that emotional abuse during childhood was associated with an increased risk of adult mental health problems independent of other forms of childhood abuse experiences. Moreover, its presence with each of the other forms of abuse enhanced its link with adult mental health problems.

Other large-scale studies have investigated the link between childhood adversities and adult mental health and substance use disorders. Unlike the former, which were based on individuals' self-reports of symptoms or mental health problems, these community studies used diagnostic criteria developed by the American Psychiatric Association (1987, 1994, 2000) to estimate the prevalence of various disorders in the population and link such disorders with different risk and protective factors. Perhaps the best known of these studies is the National Co-morbidity Study (NCS), which involved interviews with a nationally representative sample of close to 6000 women and men between the ages of 15 and 54 (Kessler et al. 1994).

Several papers have been written with these data to show the link between childhood victimization experiences and the subsequent onset of different disorders (Kessler, Sonnega, Bromer, Hughes, & Nelson, 1995; Kessler, Davis, & Kendler, 1997). Such analyses show that interpersonal victimization experiences, particularly rape and sexual molestation, but also physical assaults, are among the most traumatic life experiences reported by women. Moreover, such events have a high probability of being associated with the subsequent onset of several disorders, including post-traumatic stress disorder (PTSD), manic depressive disorder, drug problems and dependence, major depressive disorder, alcohol problems, and other anxiety disorders (Kendler, Bulik, Silberg, Hettema, Myers, & Prescott, 2000; Molnar, Buka, & Kessler, 2001).

Such disorders typically do not occur alone but tend to covary. Indeed, the National Co-morbidity Study was commissioned by Congress to study the high rates of co-occurring disorders in the general population. Kessler and his colleagues (1994) found that a significant portion of the population, and particularly women, reported multiple disorders, including the co-occurrence of mental health and substance use disorders (Kessler et al., 1996). Further, findings show that co-occurring mental health and substance use disorders are more common among women with abuse histories than among women who have had not had abuse histories (Newmann and Sallmann, 2004).

Adult Victimization and Mental Health/Substance Use Problems

With the exception of the National Violence Against Women Study discussed earlier, It is interesting that there have been fewer studies of the link between adult victimization experiences and mental health or substance use problems. Most that have been done focus on intimate partner violence (IPV). In an analysis of findings from earlier published studies, Jacqueline Golding (1999) concluded that women with a history of IPV are 4 to 6 times as likely as women without such a history to report mental health problems. Such problems included more symptoms of depression, a greater risk of suicidality, PTSD, alcohol abuse, and drug abuse. A more recent review of studies by Briere and Jordan (2004) concluded that studies of physical and sexual assault within and outside of marriage have been associated repeatedly with increased anxiety, depression, cognitive disturbance such as hopelessness and low self-esteem, posttraumatic stress, dissociation, somatization, sexual problems, substance abuse and suicidality. Moreover, they note that "...similar findings have been reported for victims of stalking, partner psychological maltreatment, sex trafficking, and in women who have experienced sexual torture" (p. 1254). Finally, a recent longitudinal study of men and women found that young adult women who became involved in an abusive relationship were more likely than other women (or men regardless of victimization status) to subsequently develop multiple disorders (Ehrensaft, Moffitt, and Caspi, 2006). The specific disorders they were at higher risk for included: a major depressive episode, marijuana dependence, PTSD, and generalized anxiety disorder.

In sum, as with child abuse experiences, women who are victimized as adults are at greater risk than women who escape interpersonal violence for a range of mental health and substance use problems. Moreover, the cumulative effect of multiple forms of intimate partner violence (physical, sexual, and psychological abuse), as with child abuse, seems to contribute to a greater risk of subsequent symptoms (Basile, Arias, Desai, and Thompson, 2004).

The finding of complex diagnostic histories linked with both childhood and adult victimization experiences has led to a good deal of debate about the utility of current diagnostic frameworks for capturing the full array of symptoms and/or disorders that are linked with abuse experiences. Two strands to the debate are worth noting, particularly in light of the stories of women we shared earlier. They are linked in a common critique of the diagnosis of post traumatic stress disorder (PTSD) as "the only or even the central posttraumatic response following exposure to

potentially traumatic events, particularly if such events involve child victimization or chronic, severe interpersonal violence that occurs at any age" (Kilpatrick, 2005, p. 379).

One can see in the earlier accounts of women that the traumatic life experiences they reported are typically not single events, like a tornado, auto accident, or even the death of a loved one or a rape. Rather, they are periods of days, months, and years when one is held hostage in a situation that one is, in the short-term at least, unable to change. Typically, these are experiences that take place in one's own home, at the hands of parents, lovers, or neighbors—the very people whom one should be able to trust and rely on for care and nurturance.

Bessel van der Kolk and his associates (van der Kolk, Roth, Pelcovitz, and Spinazzola 2005) contend that such complex developmental traumas and their consequences are not adequately captured in the PTSD diagnosis. Thus, they argue for a new diagnostic category labeled *Disorders of Extreme Stress* to capture the full array of symptoms and behaviors typically associated with such experiences. Such responses include unmodulated anger and impulse control, problems with attention and dissociation, and difficulties negotiating relationships with caregivers, peers, and subsequently, marital partners. The authors note that complicated adaptations to severe and prolonged trauma are not confined to children. They are also characteristic of rape victims, battered women, and concentration camp survivors.

A second, and related, strand of work by Read, Van Os, Morrison, and Ross (2005) argues that symptoms considered indicative of psychosis and schizophrenia, particularly hallucinations, are at least as strongly related to childhood abuse and neglect as many other mental health problems. Their review of a number of studies supports this claim. Their work represents a fairly new and controversial area of inquiry—one that they assert has been minimized, denied or ignored for a number of reasons, including "adherence to a rather simplistic biological paradigm" and "fear of being accused of 'family-blaming' on the part of clinicians and researchers (Read et al., 2005, p. 331).

What we can conclude from this body of work is that exposure to traumatic life experiences of the sort described in women's stories noted above can be associated with an array of symptoms that increase the probability of several diagnoses. These include:

- Anxiety disorders, including posttraumatic stress disorder and disorders of extreme stress
- Affective disorders, including manic depressive disorder and major depressive disorder
- Substance use disorders, including both drug and alcohol disorders, and
- Psychotic disorders, including dissociative disorders and schizophrenia

This may not surprise you if you have experienced traumas in your own life and grappled with their aftermath. Moreover, if you have entered one or more systems of care for these problems, you are likely to have received multiple diagnoses organized around your symptoms. In the Women and Mental Health Study, we asked women "As

far as you know, what was the diagnosis or diagnoses for which you last received treatment?" To our surprise, women's responses ranged from 1 to 9 diagnoses with an average of 2.5. Moreover, women with histories of abuse reported significantly more diagnoses for which they were being treated than women who did not have an abuse history.

We include a number of readings written from a "trauma-informed" perspective, many written by trauma survivors and/or survivor advocates. They address some of the most difficult symptoms and reactions that women who have been physically or sexually abused experience.

Suggested Readings:

- What is Post-Traumatic Stress Disorder (PTSD) *by Sidran Foundation*
- What are Traumatic Memories *by Sidran Foundation*
- Schizophrenia, Trauma, and Recovery *by Ellen Magee*
- Women and Self-Injury *by Bristol Crisis Service for Women*
- SIV: Roots and Reasons *by Ruta Mazelis*
- In Harm's Way: Suicide in America *by NIMH*

However, you may find it helpful at this point to take a break and check in on how you are feeling and what you need to do to take care of yourself. We include two exercises in our suggested readings for this chapter that many women have found helpful in getting in touch with their own experiences and feelings, including good things in their lives. We encourage you to take some time to review these exercises before you read on.

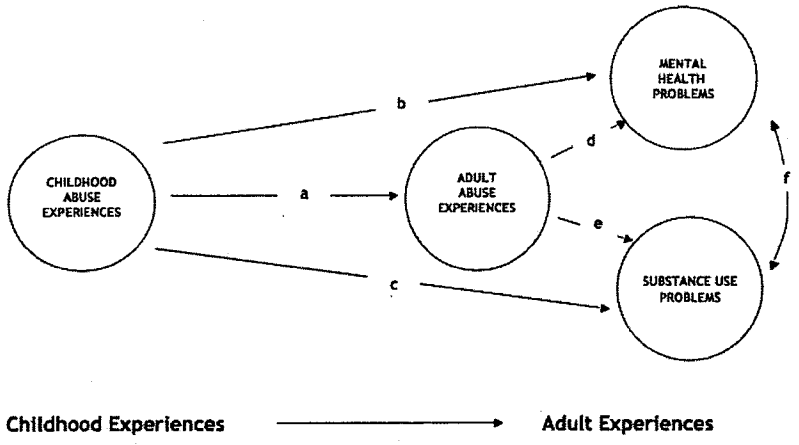
Suggested Exercises:

- *Understanding Trauma* by Mary Ellen Copeland and Maxine Harris
- *The Body Remembers What the Mind Forgets* by Mary Ellen Copeland and Maxine Harris

Pathways linking abuse experiences and mental health and substance use problems

An important question is: What are the pathways through which abuse experiences, including childhood abuse experiences as well as adult victimization experiences, are linked with mental health and substance use problems among women? One hypothesis implied by the findings we discussed earlier from the National Violence Against Women Survey is that child victimization experiences increase the risk of being revictimized as an adult. Both, in turn, may increase the risk of adult mental health problems. A number of studies show support for this "revictimization" hypothesis, which we represent below in Figure 1 with a simple path diagram (Cold et al., 2001; Noll et al., 2003; Renner and Shook Slack, 2006; Schaaf and McCanne, 1998).

Figure 1. Linking Trauma and Mental Health in Women's Lives: A Life Course Perspective



The model presented in Figure 1 represents changes over the life course in relations among four different constructs or concepts, each represented by a circle. It represents relations we would expect to find if we had information on these four life experiences from large numbers of women. The paths or single headed arrows with letters on them represent earlier life experiences that are associated with later ones. These paths can be positive or negative, but in this example, we are concluding they are all positive. Thus, path a, which has a positive sign associated with it, says that childhood abuse experiences increase the risk of adult abuse experiences. Both forms of abuse, in turn, increase the risk of mental health and substance use problems (as shown by paths b and d to mental health problems and paths c and e to substance use problems).

Another way of expressing these relationships is: Based on the findings we have reviewed so far, the more complex and prolonged the childhood abuse experiences, the more likely a woman is to develop a mental health and/or a substance use problem as an adult. This is partly due to the fact that childhood abuse experiences increase the risk of revictimization as an adult, which, in turn, increases the risk of mental health and substance use problems among women. However, the model says

that child abuse experiences also have a direct impact on the risk of adult disorders independent of its link with revictimization experiences. Finally, we show a double-headed arrow (f) between mental health and substance use problems to designate that they are likely to both be present. Further, we hypothesize that f is a positive value (+), meaning that the two often occur together, but we do not specify that one is causally prior to the other.

Now we are going to add other paths to the model to begin to fill in possible pathways that might link abuse experiences with adult mental health problems. We do so drawing on several different theoretical perspectives that are important for you to know as they shape different approaches to treatment, as well as different ways one might think about or approach one's own recovery efforts. We start with the concept of other life adversities that might occur across the life course.

1. Other Childhood Adversities

Some investigators have hypothesized that childhood abuse experiences may be less important in the development of mental health or substance use problems than are other childhood adversities that typically occur in the lives of children who are also abused. For example, some studies (as well as some of the women's accounts discussed earlier) show that children who are abused grow up in families that are fraught with other adversities, including parental psychopathology, poverty, family disruption, and a host of other environmental adversities that may be as important as the abuse itself in contributing to the subsequent development of mental health problems. In the ACE studies as well as studies by Kendler and his associates (Kendler et al., 2000) and Molnar and her associates (Molnar et al., 2001), investigators found that even when you measure and control for such adversities, there is still a strong link between childhood abuse experiences and the onset of adult psychiatric and substance use disorders.

2. Other Adult Adversities

A second and related explanation for the link between childhood abuse experiences and adult mental health and substance use problems has been proposed by Horwitz and his colleagues (Horwitz, Widom, McLaughlin, & White, 2001). They note that one of the theoretical deficiencies of most studies is "...the assumption that there is a simple causal direction leading from childhood abuse and neglect to mental health outcomes in later life" (p. 185). They argue that a "life course perspective" makes more sense in that it assumes that subsequent life changes, including the strength of adult marriages and other social relationships, as well as educational and occupational attainment, play an important role in determining whether childhood adversities will result in subsequent mental health problems. In their own study of abused and neglected children grown up, who were compared with a control group of non-abused children, both followed for a twenty year period, they conclude that the greater exposure of abused children to adult adversities is the key pathway accounting for their adult mental health problems (Horwitz et al., 2001). In Figure 2 below, we show a second model that incorporates both childhood and adult

adversities as additional pathways through which abuse experiences may be linked with mental health and substance use outcomes.

Figure 2. Linking Trauma, Other Life Adversities, and Mental Health in Women's Lives: A Life Course Perspective

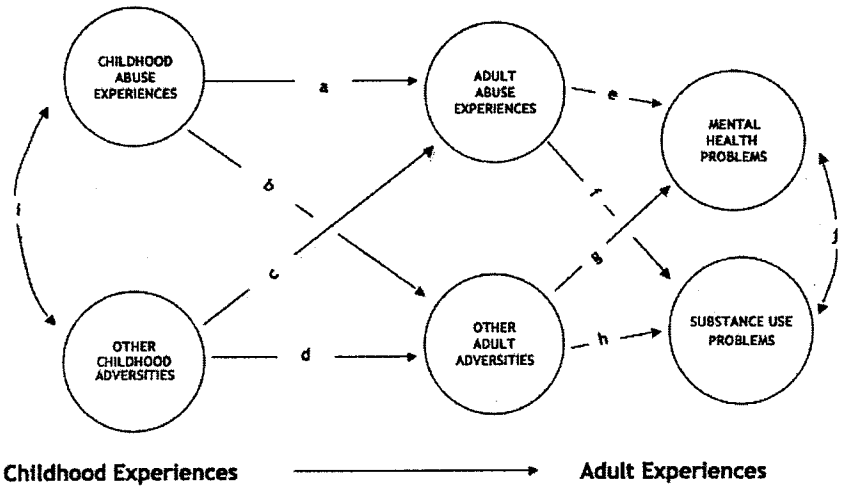


Figure 2 differs from Figure 1 in several ways, a key way being that childhood abuse experiences no longer have a direct effect on mental health or substance use problems among adult women. Rather, they are mediated (have effects that are indirect) entirely through their association with an increased risk of adult abuse experiences and other adversities. Similarly, other childhood adversities have effects that are largely indirect and mediated through pathways c and d—their association with an increased risk of adult abuse experiences and other life adversities.

3. Coping Resources and Resilience

You may be wondering at this point what about a woman's actions or sense of personal control in all of this? Don't women, or girls, try to get away from bad situations or do something to prevent adverse circumstances from occurring? The answer is yes...they do many brave and courageous things to prevent bad things from happening to them. But for many reasons, they sometimes do not have the coping resources they need to protect themselves, or they cope in ways that are ultimately harmful to them. Indeed, when we asked women in the WAMHSS study what aspects of their lives they would like to change looking into the future, and what they would need to help them make those changes, virtually all of the women pointed to a need for what we called "coping resources." Below, we discuss three kinds of coping resources that women mentioned most frequently as critical in their personal growth and change goals. We refer to them as ***personal coping resources, interpersonal coping resources, and material coping resources.***

Personal Coping Resources and Resilience

Much of the research, as well as writings of consumers, has focused on the individual's emotional and behavioral responses in the face of adversity that contribute to mental health problems over time. Indeed, as Laurie Ahern argues, one can think of mental illness as a coping mechanism (Ahern, 1999). Similarly, Carin Mizera, a practicing clinician and member of New Partnerships for Women, Inc. in its early phases, developed a model to explain the process whereby a traumatic life experience is confronted, dealt with, and resolved or unresolved over time. Using this framework, Theresa Swoboda (2002) described her own life experiences to illustrate both resolved and unresolved traumas in her life and how her own coping behaviors were effective in some instances and not in others, due in large part to the nature of the trauma. We include both of these readings because they offer consumer/survivors' perspectives on the role of personal coping behaviors in the development of mental health problems over the life course.

Suggested Reading:

- *Mental Illness is a Coping Mechanism* by Laurie Ahern
- *May the Circle Become Broken* by Theresa Swoboda

Personal coping responses are often conceptualized as ways we typically respond in the face of adversity. As we see in the women's stories, there are many examples of what we might think of as active problem-solving or what some refer to as "problem-focused coping"—Y'kana's going to her friends house to avoid physical violence at home, saying "no" to her friend's father's sexual advances; Mary's running away from home to escape physical abuse, Moonbeam and Truth's reliance on religious faith and practices, and virtually all of the women seeking the help and support of books, friendship circles, and counselors. At the same time, there are examples of self-destructive behaviors and what some have referred to as "emotion-focused coping," including self-blame, social isolation, suicidal thoughts and self-injury, promiscuity, eating problems, and abuse of substances.

The general assumption underlying much research on the link between abuse experiences and adult mental health problems is that abuse experiences erode effective coping behaviors which, in turn, contribute to more life adversities and a greater vulnerability to such adversities once they occur. Schumm and his associates (2005) refer to the "double-barreled burden" of child abuse and current life stressors on adult women as a "kindling effect." Kessler, Davis, and Kendler (1997) offer a similar explanation for the link between childhood adversities and adult mental disorders: "One widely held notion is that childhood adversities create enduring intra-psychological vulnerabilities that heighten emotional reactivity to adult stress." (p. 1102).

What might account for this heightened emotional reactivity or kindling effect? Penza, Heim, and Nemeroff (2003) suggest that childhood abuse experiences bring about neurobiological changes that are triggered in the face of adversity. Such changes involve neurotransmitters that are essential in coordinating behavioral,

immune, and endocrine functions in the human stress response. A set of neurotransmitters that is well known to most people is adrenalin. Adrenalin has very powerful effects when released into the bloodstream in response to trauma and stress. These effects not only include a rise in heart rate and blood pressure, but also changes in gastrointestinal activity, decreased appetite, disruption of sleep, heightened startle response, fear conditioning and the enhancement of shock-induced freezing and fighting behavior. Such reactions, which were described earlier in the chapter, can become persistent and recurring resulting in a neurobiological vulnerability to the effects of stress later in life. But there are other explanations for such a heightened vulnerability to stress, which we discuss below.

Interpersonal Coping Resources

A second important type of coping resource is interpersonal support—the availability of people we can call on to provide us with advice, comfort and support, and physical, as well as material, help in times of difficulty. As Bromet, Sonnega, & Kessler (1998) note, adversity in childhood is often associated with frayed or inadequately developed parental bonds, which can further erode trust and the capacity to establish close relationships as an adult. Indeed, we see this in many of the women's stories about trust, intimate involvements, even the question of having children to care for. Schumm and his associates (2005) argue that childhood abuse experiences actually contribute to "psychosocial resource loss" involving both personal and interpersonal resources, which, in turn, place women at higher risk for a range of subsequent life adversities and undermine effective coping responses. A similar idea was suggested by Molnar, Buka, & Kessler (2001) who note that: "...childhood sexual abuse, which is threatening by nature, may interfere in a developing child's sense of security and ability to trust others, leading to increased anxiety and emotional distress. Guilty feelings may also play a role; survivors of childhood sexual abuse often report self-blame and difficulty trusting others." (p. 757). Thus, this pathway suggests that women who have experienced childhood abuse may have fewer adult intimate or trusting relationships than women who have not been abused as children.

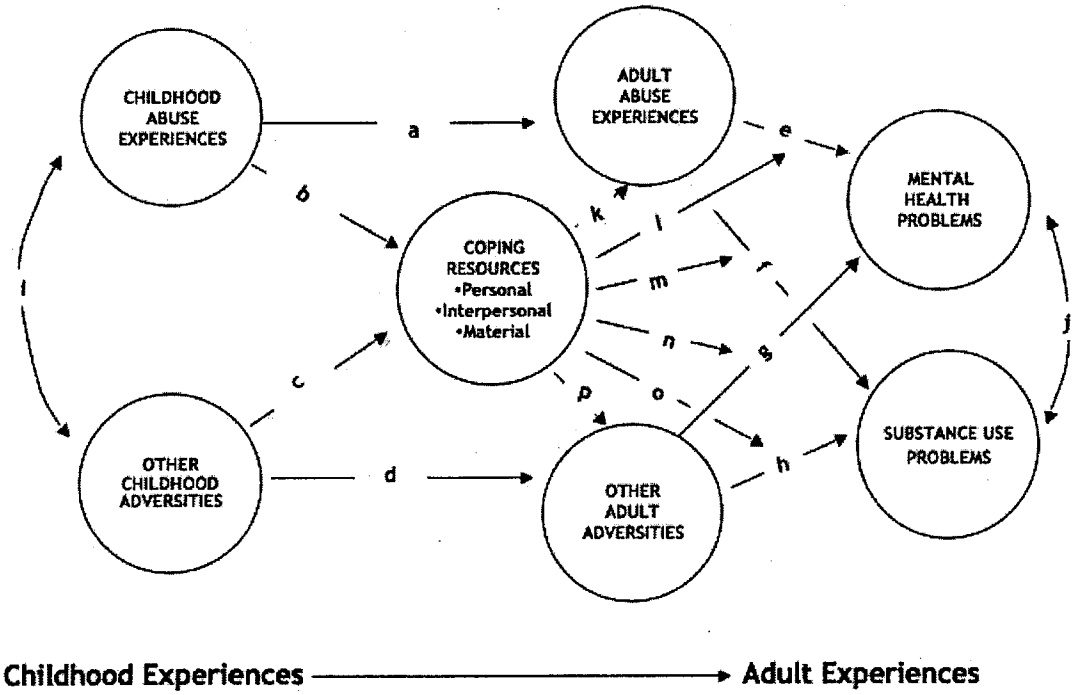
Material Coping Resources

Finally, we emphasize an important class of coping resources that emerged in our work with women who were survivors of childhood traumas—insufficient material resources. Women who use publicly funded mental health and substance abuse services are generally poorer than women in the general population, so it may not be surprising that over 60% of the women we interviewed in the WAMHSS study said the most important thing they wanted to change about their lives was to secure more material resources. In fact, most saw their own recovery as intimately linked with poverty and a need to climb out of poverty. We believe that childhood neglect and abuse, as well as adult victimization experiences, can erode a woman's earning potential through cutting short education and educational opportunities, interrupting preparation for the world of work and reducing access to needed material resources for self-care, recreation, and/or the purchase of help and resources to lead a full and

happy life. This is such an important issue for many women who have been physically and/or sexually abused that we devote a chapter to the topic.

We present one final model below that incorporates personal, interpersonal, and material coping resources as mediators, and moderators, of the abuse-life stress-mental health link. Although we represent coping resources as one circle in the model, rather than three, we think it is important to recognize that such resources can make distinct contributions to well-being across the life course and can change in relation to one another over time. Moreover, we believe that learning and change can take place across the life course and much of our work together in subsequent chapters will focus on ways to change one's personal, interpersonal, and material coping resources. Let's turn now to the picture to show you what we mean by mediation and moderation—fancy terms that researchers use in their work and that clinicians are guided by as well.

Figure 3. Linking Trauma, Other Life Adversities, Coping Resources, and Mental Health in Women's Lives: A Life Course Perspective



Mediation means that something, such as coping resources, is the pathway through which a former concept (circle), like childhood abuse experiences or other childhood adversities, affects a later outcome like adult adversities or mental health outcomes. In general, coping resources are thought to be good or protective of mental health. This is done, in part, through reducing adult abuse experiences (path k) or other adult adversities (path p). If childhood abuse experiences and other

childhood adversities erode coping resources, this becomes an important pathway through which early adversity affects later mental health.

Moderation means that something, again like coping resources, changes the relation between two other things. This is shown in Figure 3 by the paths labeled l, m, n, and o. Paths l and n show that coping resources reduce the risk of developing mental health problems among women who are abused as adults (path l) or who are exposed to other adult adversities (path n). Paths m and o show the same moderating process in relation to substance use problems. In other words, although adult abuse experiences and other life adversities increase the risk of developing a mental health or substance use problem or both, if you have good coping resources, you are at much lower risk because of their protective role.

One final note on the importance of coping resources and their interchangeability. Johnson and Lindblad (2006) studied a group of women who had experienced child sexual abuse and asked: What coping resources are most protective in preventing adult mental health problems? They found that women at high risk (because of the severity of their abuse) who had either good personal coping resources *or* good sources of social support had much better mental health scores than women at comparable risk but who had poorer personal coping resources or fewer effective sources of social support. Finally, when they included all protective factors in their final analysis, they concluded that self-esteem (a personal coping resource) and social supports (an interpersonal coping resource) were the strongest predictors of positive mental health.

System Retraumatization

We want to address the significance of social supports, not only because the women's stories we presented earlier highlight the importance of social supports in their lives and recovery process, but also because finding caring and trustworthy sources of social support is, for many women, a long and difficult journey. In fact, many women with trauma or abuse histories have experienced retraumatization within service systems designed to provide care. This often happens because the service providers, such as the counselors and other caregivers in the mental health, substance use, or physical health care systems do not understand how a trauma or abuse history may affect a woman. We have included a number of women's stories about these kinds of experiences in your Study Guide and suggest you read through them for a better understanding of how a service system may be experienced as retraumatizing.

Suggested Readings:

- *Anna's Story* by Ann Jennings
- *K's Story* by Anonymous
- *A Couple of Barb's Stories* by Barbara Hennings
- *An Outrage of Institutions* by Anonymous

Exercises for Understanding and Coping with the Effects of Trauma

We have provided you with a lot of information about trauma and the ways in which it may affect your life. We understand that the amount of information may seem overwhelming at first. We do want you to remember that we believe that it is possible to live happier and healthier lives by addressing the effects of trauma. We also want you to remember that we believe that healing and recovery are possible and have seen it happening in our own lives. Earlier we referred to two exercises that might help you understand trauma and some of the ways it may be affecting your life. If you have not taken the time to go through these exercises, you may want to do so before you read on. On the other hand, the chapters that follow are designed to give you additional tools to make progress in your own self-discovery process.

Suggested Exercises:

- *Understanding Trauma* by Mary Ellen Copeland and Maxine Harris
- *The Body Remembers What the Mind Forgets* by Mary Ellen Copeland and Maxine Harris

The next chapter of the *Study Guide* will focus on providing you with a variety of tools for how to manage some of the symptoms of trauma you may be experiencing within your own life.

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