The Link Between Childhood Trauma and Mental Illness

Effective Interventions for Mental Health Professionals

Barbara Everett / Ruth Gallop

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Introduction

Many people seeking help from the mental health system have histories of childhood trauma, defined in this work as sexual and physical abuse. In fact, up to two thirds of women hospitalized in psychiatric settings report a history of child abuse. Although many authors write on the topic of specialized therapy for abuse survivors, little is available for other mental health professionals, such as psychiatric nurses, case managers, rehabilitation counselors, crisis and housing workers, occupational and physical therapists, family physicians, and social workers. These important practitioners are often the first to hear about abuse, and they are likely to be caring for clients experiencing the severest consequences. They see firsthand the devastating results of child abuse, and they have a crucial role to play in helping clients heal and recover. They also have learning needs that differ from those of trauma treatment professionals. This book is designed for them.

Our goals are twofold:

1. To provide mental health professionals who are *not* childhood trauma specialists with particular forms of knowledge and skills relevant to their direct service role and practice context. These professionals need to know when it is appropriate to ask clients about an abusive past, how

to listen to disclosures with sensitivity, and how to integrate this information into their helping strategies.

2. To introduce a conceptual bridge between biomedical and psychosocial understandings of mental disorder—a multidimensional approach that allows professionals to think in holistic terms and to link clients' abusive pasts with their present-day symptoms and behaviors.

Although each chapter can be read independently, the book is designed as a progression, with each part building upon the previous one. The first section is focused on providing the knowledge necessary to think critically about the many issues and debates that affect how mental health professionals in a variety of roles and settings provide services to survivors of childhood trauma. In Chapter 1, we briefly review the systemic and individual barriers that inhibit the acknowledgment of child abuse as an important factor in clients' backgrounds and constrain the inclusion of this information in our helping strategies. Next, we present a unique multidimensional model of understanding that unites, in a holistic relationship, factors such as the specific nature of the abuse, social and cultural values, genetics and biology, interpersonal relationships, and a sense of self and worldview. Chapters 3 and 4 review the research knowledge about the prevalence of childhood trauma and its potential impact in adult psychiatric and nonpsychiatric populations. Chapter 5 discusses not only the possible ways traumatic memory is stored and recalled, but also the controversial issues of recovered memory and false memory syndrome. Finally, as a lead-in to the book's second section on practice issues, Chapter 6 introduces the topic of asking about child abuse. For many mental health professionals, asking clients about their abusive pasts is anxiety producing. We believe the guidelines in this chapter will facilitate comfort for both the professional and the client.

Part 2 of the book is focused on client-professional relationships and active practice strategies. In Chapter 7, we consider the nature of power in the helping relationship by discussing both "power over" and "power with." Given the centrality of abuse survivors' experiences of both powerlessness and the misuse of power, understanding how power works in the mental health system as a whole, as well as in client-professional relationships, is critical. Chapters 8, 9, and 10 highlight issues such as the full recovery process; credible treatment models; the creation of basic rela-

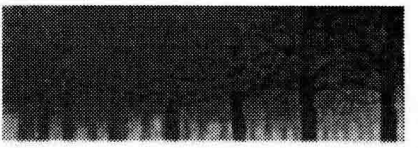
tional, emotional, and physical safety; and ways to listen to clients' stories so that, as professionals, we can make sense of what we are hearing.

In the book's last chapters, we address special topics by utilizing the expertise of three guest authors. Dr. Lee Ann Hoff, an authority in crisis theory and practice, considers the abuse survivor who is overwhelmed by crisis events. She provides both a theoretical basis for action and practical guidelines for offering care and intervention. A chapter is also especially devoted to men's concerns, because research and clinical literature have been focused predominantly on women. Although we have tried to ensure that the book's previous sections are applicable to men as well as women, John McManiman provides his own insights into the needs of men. Dr. Kathy Lawrence works with the families of survivors of civil war and torture, and she writes about the special issues facing clients from diverse ethnoracial and ethnocultural backgrounds. Finally, we address personal and professional self-care, because working with survivors of childhood trauma has special dangers, such as secondary trauma and vicarious traumatization, both of which go well beyond burnout.

As joint authors, we represent a partnership between theory and practice that has functioned as a unifying force in our own thinking. Throughout the writing of this text, we have endeavored to present a balanced review of current models, practice strategies, and controversies. It is our hope that our work will deepen professional understanding of the link between childhood trauma and mental disorder and improve the capacity of mental health professionals to provide real, meaningful help.

NOTE

1. Emotional abuse is also a component of childhood trauma, but there is little research defining its consequences. Thus, the principal focus of this text will be sexual and physical abuse.



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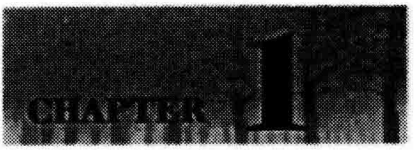
PART 1

THEORY AND KNOWLEDGE



Why We Often Miss a History of Childhood Trauma

Our culture's view of childhood is built upon images of sweet-smelling babies, chubby hands dragging teddies, pony rides, science projects, piano lessons, prom dresses, and graduation ceremonies. Sadly, for many children, the list would be more accurate if it included broken bones, chipped teeth, black eyes, burns, unexplained vaginal or anal infections, night terrors, empty stomachs, and lonely hearts. Children are the world's most precious resource, and the idea that society may be doing a poor job of keeping them safe is challenging enough; to imagine that trusted adults specifically charged with their care are committing atrocities such as beating, raping, torturing, or starving them remains somehow inconceivable, despite increased media attention and regular exposés.

As mental health professionals, we work in a world where a history of child abuse is the sad reality for many of our adult clients. But we, too, are products of our society, and as a consequence, we can be forgiven if we struggle to maintain our illusions. Eventually, however, we have to confront the facts if we are going to provide meaningful help. In this chapter, we discuss the many individual and systemic barriers that can interfere with our capacity to understand and respond to our clients' experiences.

Before beginning this discussion, it is vital that we remind ourselves that the denial of abuse can also mean the denial of recovery. We ask, "If you are well now, then it couldn't have been that bad, could it?" Despite beginning life amidst horror and living in a culture that prefers to turn its back on abuse, survivors of childhood trauma can and do heal. Hope is often the only light that guides their journey and optimism the most valued asset of those who assist them. Children can endure abuse at the hands of those they would have loved and not only retain their humanity but grow into competent, caring adults who value other humans even as they themselves were not valued.

O'Connell Higgins (1994) defined *resilience* as "a firm refusal to join the ranks of the sour and dispirited" (p. 319). However, resilience is much more than making it through. It is a process of "self-righting" in which hurt children become adults who have learned to grow and develop instead of wither and die. They are capable of acknowledging both their suffering and their losses while at the same time cultivating a capacity for love. These are people who have been denied the chance to become the adults they would have been had the abuse never occurred, but they do not re-create hatred and violence in their own lives.

The field of mental health might be more properly called the field of mental illness, because researchers and clinicians tend to focus almost exclusively on what has gone wrong, rather than on what has gone right. Mental health professionals encounter their clients when they are at their lowest ebb, and research findings typically offer a static snapshot of this unhappy moment. Wellness is something that happens outside hospital walls and beyond the clinic door. As we proceed through our discussion of the many barriers that impede our understanding of survivors of childhood trauma, it is important to recall two realities: Small children can be subjected to the basest acts of cruelty, *and* they can defeat these violent impulses by becoming adults who are capable of both giving and receiving love.

SYSTEMIC BARRIERS

Systemic barriers refer to largely invisible but nonetheless powerful social beliefs and values that either suppress our ability to recognize child abuse or encourage us to ignore it.

The Family as Sacred. Children, who are the most vulnerable members of society, remain largely unprotected, walled off from public scrutiny by the agreed-upon sanctity of the family. Family values are held up as a universal but rarely explained ideal, and the wholesome nuclear family remains one of our most cherished myths. That many marriages end in divorce, that some parents live in poverty, and that some neighborhoods are violent are realities that hover on the edge of social consciousness. Ultimately, these facts do nothing to erode the central belief that, generally, children are reared in plenty and in safety. Indeed, most parents are not abusive, but many are alone, unsupported, and ill equipped for the never-ending demands of child care. Others are poor, struggle with their own illnesses or substance abuse problems, or live in violent relationships. And a few, a very few, it must be stressed, are viciously and sadistically abusive, targeting their own defenseless children as objects of hatred. These are facts that are hard to reconcile with our need to see the family as the benign building block for all society.

Authority should not be questioned. People in positions of authority are viewed as trustworthy, not necessarily because they have personally earned that trust but because of the valued attributions we assign the roles they occupy. Priests, ministers, teachers, doctors, scoutmasters, coaches, and others are respectable by definition, and sanctions exist for those who question their authority or fail to follow their orders. Power inequities without the benefit of the checks and balances of accountability mean that abuse *can* occur even though most people conduct themselves with integrity. We admire powerful people and trust that they will treat our children with wisdom and kindness. The fact that some do not is hard to believe.

Violence is normal. We are surrounded by violence. It is in our homes, schools, and neighborhoods. It is reported in the newspaper and on the