

NOTES TO ACCOMPANY DIAGRAM OF THE SOCIAL / TRAUMA MODEL

- Although the diagram and notes are designed specifically with reference to childhood experiences of sexual abuse they are generally applicable to adult sexual assault / abuse experiences, other forms of childhood abuse, disrupted childhood (e.g. being in care), trauma, domestic violence, sexual harassment, many forms of oppression and similar life events. The notes will, however, specifically refer to childhood sexual abuse experiences.
- Not all survivors of sexual abuse and similar experiences face all of these difficulties or to the same degree. Responses to abuse experiences are as individual as the survivors and reflect a wide range of factors including their personal qualities, support structures, type and duration of abuse, relationship with the abuser, response to disclosure, degree of threat used in coercion and the cultural, gender and class contexts which define the individual.
- These connections are a result of my experience as a specialist mental health social worker and are therefore my opinion and not the result of research or experiment. However, I have shared them both with other people working in this field and with abuse survivors and they have generally felt that they reflect their experiences.
- The diagram is a simplification of a complex set of inter-relationships. It is not comprehensive, if it was it would be impossible to decipher.
- Written across all of this could be, in large red letters, the word FEAR.
- Other themes that run through the model are those of:
 - ❖ Binary responses, often extremely opposed, that the person may experience one or the other of, or may oscillate between.
 - ❖ Distortions of reality, both 'given' and created.
- Apart from the part called "abuse" in the circle, what is demonstrated in the diagram are all logical, rational and necessary for the person to achieve the human being's "prime directive" (survival), given their experiences.

Guilt and Shame

The way that abusers go about abusing, the way that children see the world, the responses of others to abuse and their sense of isolation all ensure that people who are sexually abused in childhood, or experience other oppression, believe that they are responsible for what has happened to them. Feeling responsible for the abuse and guilty and ashamed of its sexual nature leads to the survivor hating themselves. Because they hate themselves and have been treated as creatures of no worth they cannot value themselves. This produces low self-esteem, they lack self-confidence and believe themselves to be worthless. They also believe they are unable to protect themselves. Feeling they have neither the right to survive alone, nor the capabilities to do so creates feelings of dependency. Self-hate causes self-directed anger, a cause of depression. Feeling worthless causes feeling of hopelessness, feeling unable to protect oneself causes feelings of helplessness. Hopelessness and helplessness are key feelings in depression.

Anger

Anger at abuse and the betrayal of trust is a valid response. Anger can also be a positive energy for change. However, turned inwards it can be very damaging. Behaviours such as cutting, bulimia (and to an extent anorexia), alcohol and substance misuse are all ways of being angry with oneself. Outwardly directed anger can also be problematic when it is inappropriately directed or appears unexplained. High levels of apparently unexplained anger can attract psychiatric labels such as mania and personality disorder. It can also lead to legal difficulties and a criminal record.

Inability to Trust – Boundary Difficulties

One of the main features of abuse by an adult or close relative is that it is a betrayal of trust. It undermines any sense that other people, or oneself, can be trusted. This leaves feelings of anxiety and vulnerability.

Abuse and oppression are all transgressions of boundaries. Abusers often “groom” their victims by damaging other “innocent” boundaries. People who have had their boundaries damaged often struggle with boundaries generally and experience anxiety and insecurity by not being able to identify and rely on boundaries.

Vulnerability and Unassertiveness

If you believe you cannot protect yourself, you feel vulnerable and powerless. If you believe you have no worth or right to protect yourself, you will be unable to assert your own needs and wants. You may find yourself in an abusive relationship in adult life when you can / will not protect yourself. If abusive relationships are what you grew up with, if you believe that you caused and deserve the abuse, then you will feel very anxious and confused in non-abusive relationships, expecting them to end up like all the others. Sometimes, it can relieve your anxiety if you can push the other person into becoming abusive, because you know the rules of that game, and it fits with your view of yourself and the world. If you feel vulnerable you are afraid of being or appearing weak. This leads to a need to maintain a strict control of everything in the environment, particularly feelings of anger and grief, both of which are logical and appropriate results of being abused. One of the causes of anorexia is a need to control food intake and body weight because of a feeling of being unable to control anything else.

“Being a doormat”

If the world is threatening and you believe you are powerless, then it is very much in your interests to make sure that everyone likes you so no-one will harm you (hard, because you do not believe you deserve to be liked so you have to work even harder). Pleasing everyone becomes very important, with considerable distress if you feel you have upset them. Authority figures (because of the power / authority of the abuser) feel very threatening and must especially be pleased / appeased. This results in submissive behaviour (perhaps replicating the submission inherent in the abuse), heightened awareness / fear of pleasing / displeasing others and increased attachment seeking behaviour. This can appear to protect from further abuse but may also render the person more vulnerable to that abuse.

Anxiety

Feeling vulnerable and unable to protect oneself, feeling there is no one who can be trusted, being in a situation where physical or sexual abuse are still happening are all causes of anxiety. Worry about being hurt or abused again, that your own children may be abused (or even that you may abuse your own children) and particularly worrying about people finding out that you have been abused all create a constantly heightened level of anxiety. Panic attacks and phobias are both results of high anxiety levels.

Sexual Difficulties

It is not surprising that first experiencing sexual activity as frightening, coercive, confusing, shrouded in secrecy and often painful and physically harmful does not create a sense of sexuality and its expression being desirable, mutual, pleasurable or even safe.

Many survivors' sexual pleasure in adult life is also blocked by learned techniques of emotional and sensate withdrawal. Choosing not to experience sexuality either with the self or other is one way of dealing with this. However, feelings of vulnerability and dependency can leave survivors feeling unable to remain outside romantic relationships and thus often unable to withdraw entirely from sexual activity.

Feeling a lack of free choice in expression of sexuality, either through a sense of duty or through overt coercion from the partner is an echo of the coercion and helplessness present in the first abusive experiences. Even with a sensitive and consciously non-coercive partner, the feelings, sights, smells, sounds and fact of sexual activity can all recall the abusive experiences and result in either withdrawal, distancing or "flashbacks".

Withdrawal from sexuality is one response. Confusion between sex and love, a sense of being already "used goods" and unclear sexual boundaries can all lead to unsatisfying sexual experiences that it may not be possible to limit. Many children who are sexually abused receive sex when what they are hungry for is love and positive attention. If the abuse is accompanied by rewards in either money or kind, it can result in sexual activity being seen as both a tool and a weapon. In adult life the search for a sense of worth and being loved, as well as a need to protect oneself or to survive economically can all lead to sexual activity which is not mutual, pleasurable and chosen activity.

Avoidance of Pain (dissociation)

The original abusive experiences were painful, both emotionally and usually physically. The feelings of guilt, anger, self-hate and shame are still painful.

At the time of the abuse many survivors coped by withdrawing, or dissociating themselves from the pain. This is done by either believing that what is happening is happening to someone else, or that the person is actually not there at all. Survivors have been able to achieve extraordinary abilities to not experience pain and at the time this is a functional and very effective defence. One survivor has described to me how she had an imaginary friend who was the one who experienced the pain and fear, not her. Many abusers threaten their victims in case they tell someone about what is happening to them, or express their anger about their experiences. Thus anger or telling become unacceptable. The abuser may also tell the victim that they are bad, wicked, dirty and in order to survive such self-destructive beliefs they may also be compartmentalised. Such habitual separation of feelings and urges from the "self" as consciously experienced can mean that

they are experienced as "other", outside the self and perceived as voices. They can also be experienced as "multiple personality disorder". Another survivor has described to be how she can feel and express anger when operating as a different self, with a different name, which dresses and behaves differently.

Repressed or extremely painful memories may only be experienced as "flashbacks", sometimes accompanied by the voice and behaviour regressing to the time of the memory. The survivor is, as far as they are concerned, actively re-living the event and sounds and sights of that time seem really present. To anyone observing this process the voices and sights are not real, i.e. they are hallucinatory.

Experiencing flashbacks and memories can intrude into a survivors' current attention - they "tune out" and lose the ability to concentrate.

Habitual emotional withdrawal as described in the section about sexual difficulties can produce an inability to connect with emotions and feelings. This can be seen as an emotional flatness.

Post Traumatic Stress (Disorder) can reflect many of the effects of dissociation, and indeed dissociation is the dynamic leading to much of this range of effects of trauma.

Avoidance of Pain (Self-Harm)

Abuse survivors feel current pain. This is made up of memories of pain, pain at negative feelings and pain at the difficulties of living with all the consequences of the abuse. Many survival techniques, useful and appropriate at the time of the abuse, may now be destructive and dysfunctional and cause current pain.

Pain can be avoided in many ways, either by blocking it by use of alcohol and prescribed and illegal drugs or by substituting a more controlled and physical pain. Physical self-harm such as cutting, burning or other self-inflicted injury brings genuine relief, albeit temporary, from emotional pain, because it is in the control of the survivor and the emotional pain is not. The bingeing, vomiting and laxative abuse behaviour in bulimia bring the same relief.

Abuse of alcohol can have an additional "benefit" for survivors as it can help to access memories and feelings otherwise not accessible. Alcohol, prescribed and illegal drugs can also be experienced as very helpful in getting to sleep and in preventing distressing and frightening dreams.

Unfortunately, all these pain-avoiding techniques have their own attendant difficulties. They add to the feelings of self-hate and disgust. They also block the healing process of experiencing and resolving the feelings resulting from the abuse.

For many survivors the pain, helplessness and hopelessness are too much to bear and the ultimate pain avoidance is death. Urges to take overdoses or commit suicide are often very strong and can be ever-present.

Poor Relationships and Isolation

It is no coincidence that ultimately all the arrows seem to lead back to the box marked "poor relationships / isolation".

Feeling guilty and anxious about people finding out about the abuse makes it feel safer to avoid close friendships and relationships. Feeling unworthy, dirty and unlovable makes relationships seem inappropriate. Experiences of being abused, particularly when accompanied by learning that no one can be trusted, feeling vulnerable, unassertive and unable to protect oneself makes relationships seem dangerous, although sometimes apparently necessary. Sexual difficulties can lead to avoidance of sexual and romantic relationships, as can guilt about previous inappropriate sexual behaviour. Outbursts of anger, particularly if inappropriately directed, or emotional flatness all militate against good relationships. The guilt and shame attached to self-harming behaviours makes relationships seem difficult. Insecure sexual boundaries and poorly developed response to the need to feel in control can all cause problems. Additionally the stigma attached to mental illness can exacerbate these problems if the consequences of the abuse have resulted in a psychiatric history.

Potential for Psychiatric Misdiagnosis

As can be seen from the diagram of the social / trauma model, many of the difficulties experienced as a result of abuse, trauma and oppression can either be mental health problems, such as depression or anorexia, or could be mistaken for mental health problems such as schizophrenia (hearing voices, seeing things and/or emotional flattening), manic depressive illness (outbursts of anger, agitation, depression and changing emotional states) or personality disorder, in particular borderline personality disorder (self-harm, overdoses, emotional instability, impulsiveness). Research is beginning to demonstrate high percentages of people with diagnoses of serious mental illnesses who have histories of childhood sexual abuse. However, the logical, rational and necessary consequences of that abuse may not be those illnesses themselves but can be mistaken for them. I believe that this is becoming increasingly apparent.

Abuse, Trauma and Oppression – Links with Multiple Needs and Homelessness

People who have experienced abuse, trauma and oppression and who are surviving and coping within the social / trauma model are very likely to fit the description of "multiple needs". How these arise, and their relationship with adverse life events, are demonstrated by the social / trauma model. One of the ways that people cope with abuse and oppression is by escaping, often leading to homelessness due to a lack of alternative safe places. The difficulties that they experience as a result of their abuse can also lead to homelessness. Many of these difficulties can make them hard people to help and they often fall outside the boundaries set for particular services, such as self-harm, psychiatric diagnosis, suicidal feelings and difficulties in engaging. They may find it very hard to trust people and have poor social skills and boundaries.

Implications for Helping Services

The main effects of abuse and oppression are damaged boundaries and powerlessness. This has implications for how services are provided. They need to be empowering and have good, appropriate boundaries. They also need to understand that people's difficulties

are their most effective ways of coping with their experiences, given their circumstances, and these need to be respected, accepted and not judged nor punished. You cannot expect people to give up the ways that they cope unless they can find “better” ways and/or a less abusive environment.

It is essential that services do not replicate the abuse. They need to be safe, accepting, empowering, nurturing, containing and appropriately structured. Negotiation rather than coercion is essential. They also need not to be conditional in their acceptance, whilst retaining boundaries. People who have been abused and oppressed are often desperate to please, believing that it is their own unacceptability that has caused the abuse, and they need to be encouraged to make choices for their own benefit rather than to please others.

Because of the potential for psychiatric misdiagnosis, it is essential to keep an open mind in the face of such diagnoses and not to view people through the lens which defines people by their diagnosis.

Implications for Disclosure

For most abuse survivors, disclosing is a very difficult and frightening process, no matter how desperately they feel the need to do so. Difficulties in knowing whom they can trust, fear that their disclosure will be met with disbelief, blame and punishment and the threats against disclosure possibly made by their abusers are all barriers. The gender, cultural background, status and position of the person they are considering disclosing to will also help or hinder this process. They can also fear the impact of their information on the hearer, wanting to protect them from the shocking, shameful, unbelievable and “contaminating” contents. Feeling disempowered and with damaged boundaries, the survivor can only achieved sufficient safety to disclose if they are offered appropriate boundaries (including explicit boundaries on confidentiality) and empowered by the interaction.

Implications for Helpers

Trying to help someone who has been abused and/or oppressed and who is cycling around in the social / trauma model can feel very much like being in that model yourself. The traumatic content of their experiences can traumatise those they talk to about them, their damaged boundaries can disrupt the helper’s boundaries, coping through chaos can spread chaos and their sense of hurt and helplessness can make the helper feel powerless and inadequate. Repeated crises, suicidal feelings and actions, high levels of distress and despair can stress and distress those around them and trying to help them. As a result, helpers and supporters risk experiencing the effects of the social / trauma model and it is essential that they are given adequate support, boundaries and supervision as well as encouragement and permission to look after themselves. Those helpers who have themselves experienced abuse, trauma and oppression in their own lives (as many people have) are very vulnerable to having those experiences reactivated. This does not mean that they should not do this work, indeed they often have rich resources and understandings to bring to it, but that they need to have achieved a level of understanding and resolution and will require the best levels of support and supervision, as well as an ability to be honest with themselves and their supervisor about their experiences, so they can be appropriately supported.

“The abuse-focused psychotherapy message:

You have spent much of your life struggling to survive what was done to you as a child. The solutions you’ve found for the fear, emptiness and memories you carry represent the best you could do in the face of the abuse you experienced. Although some others, perhaps even you, see your coping behaviours as sick or “dysfunctional”, your actions have been the reverse: healthy accommodations to a toxic environment. Because you are not sick, therapy is not about a cure – it is about survival at a new level, about even better survival. Your job is to marshal your courage, go back to the frightening thoughts and images of your childhood and to update your experience of yourself and the world. My job, the easier of the two, is to engineer an environment where you can do this important work and to provide in our sessions the safety and respect that you deserve.”

(Briere. 1992. p83)

Links with *Women’s Mental Health: Into the Mainstream and Mainstreaming Gender and Women’s Mental Health*

The Department of Health’s women’s mental health strategy consultation document *Women’s Mental Health: Into the Mainstream* (DoH, Sept 02) and implementation document *Mainstreaming Gender and Women’s Mental Health* (DoH, Sept 03) clearly identify experiences of violence and abuse as a core theme in women’s mental health difficulties. They make a number of proposals about how mental health services need to respond to this, including staff training and support, choice of gender of helpers and women only services. These documents are clearly saying that women’s experiences of violence and abuse must be recognised and responded to. The documents are recommended reading.

(A longer version of this model can be found in the chapter *The Social / Trauma Model – Mapping the Mental Health Consequences of Childhood Sexual Abuse and Similar Experiences* in Tew, J. (ed) *Social Perspectives in Mental Health – Developing Social Models to Understand and Work with Mental Distress*. London, Jessica Kingsley Publishers, January 2005.)

Sally Plumb, 2007.

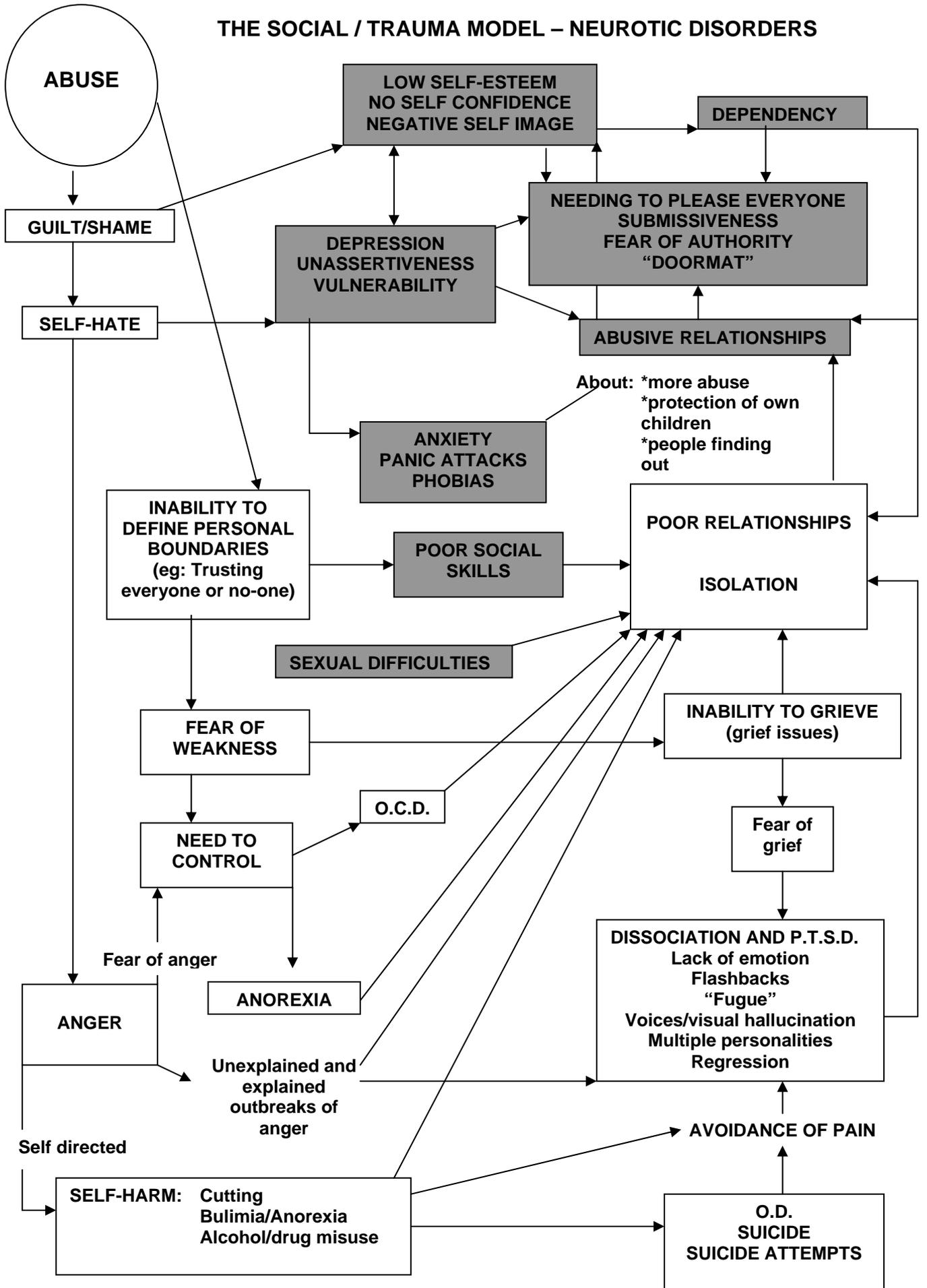
Other useful books:

Briere, J N: *Child Abuse Trauma*, London, Sage Publications, 1992

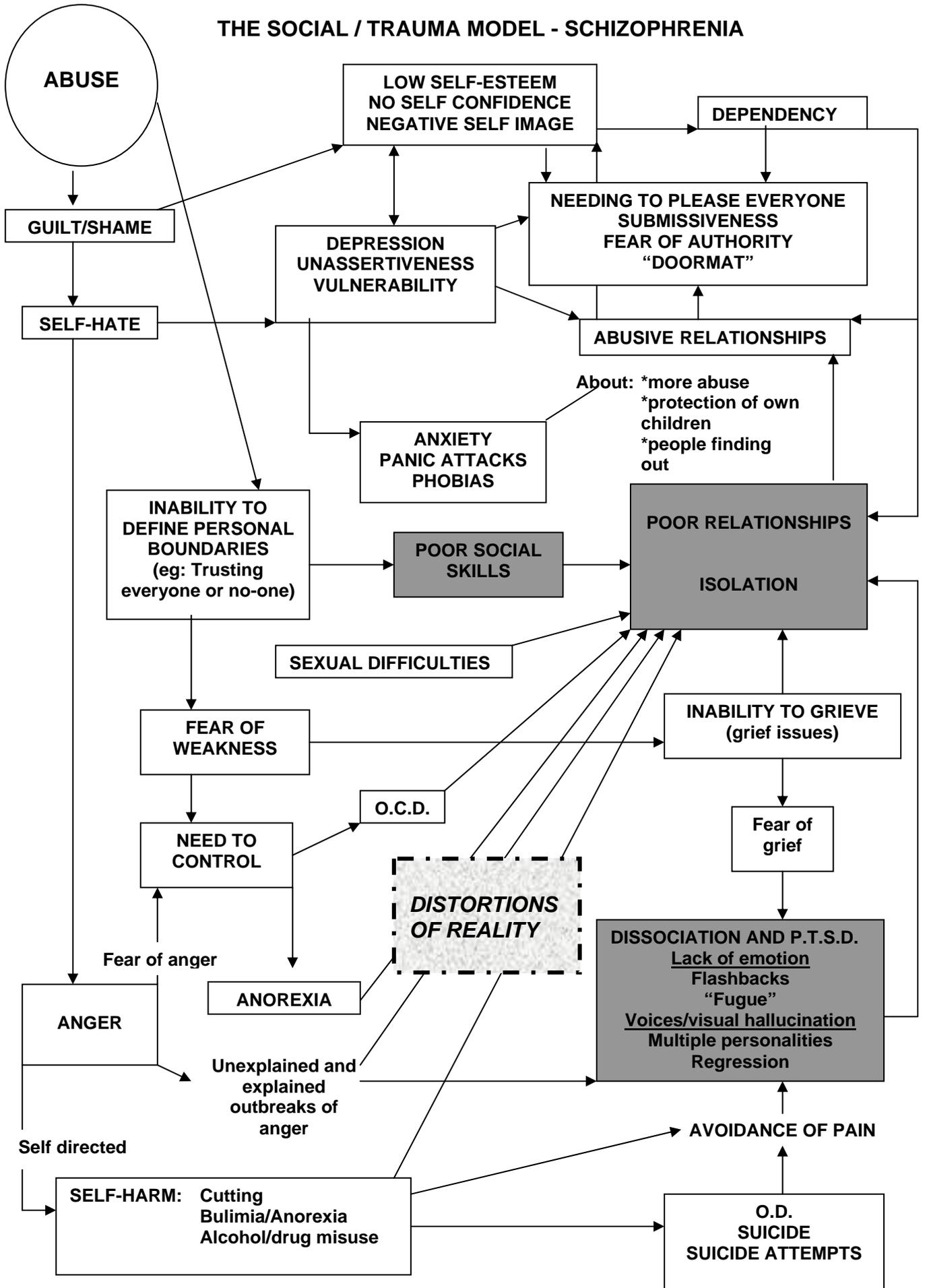
Herman, J L: *Trauma and Recovery*. London, Pandora, 1997

Sanderson, C: *Counselling Adult Survivors of Child Sexual Abuse*. London, Jessica Kingsley Publishers, 2006.

THE SOCIAL / TRAUMA MODEL – NEUROTIC DISORDERS



THE SOCIAL / TRAUMA MODEL - SCHIZOPHRENIA



THE SOCIAL / TRAUMA MODEL – PERSONALITY DISORDERS

