

CHAPTER 1

Abuse and Trauma in Women's Lives: Understanding Gender

Chapter 1 outlines the importance of taking gender and social context into account in understanding the consequences of abuse. This includes understanding the significance of gender inequality and traditional gender socialization:

- in relation to women's mental health
- in the disruption of normal development of self-capacities
- in the experience of post-traumatic stress responses.

CHAPTER 1

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GENDER, TRAUMA AND SOCIAL CONTEXT

Over the past two decades, there has been a growing recognition that significant mental health needs of women have not been adequately recognized or treated (Miller and Sholnick, 2000; Morrow and Chappell, 1999; Kaschak, 1992; Worel and Remer, 1992). Women's mental health needs are often distinct from those of men, indicating the importance of taking gender into account in understanding and responding to the psychological issues of clients.

Women's mental health needs cannot be adequately grasped without understanding the way in which they are linked to and, in many cases, emerge from women's unequal status in society. Gender is not simply an individual difference. Instead, gender is a social status and a status of social inequality, around which an entire set of social assumptions and practices are built. A gender-specific approach to women's mental health, therefore, is necessary both for understanding the mental health issues women most often face and for responding to the unique conditions of women's lives, and the impact of these conditions on women's physical and mental well-being.

Borderline personality disorder and gender

Gender plays a significant role in mental health issues. For example, over 70 per cent of people diagnosed with borderline personality disorder (BPD) are women. Those diagnosed as "borderlines" have been stigmatized as being difficult to work with and treatment-resistant (meaning that they don't respond well to therapeutic interventions).

Key symptoms of borderline that many mental health professionals found so unpalatable were responses of **emotional lability** and profound mistrust and anger expressed in what have been considered to be manipulative and aggressive ways.

There is now much greater awareness that many of the women who have been considered “borderline” are in fact experiencing complex post-traumatic stress responses (McLean, 2001; Briere, 1996). Like complex PTSD, a diagnosis of BPD has been associated with a history of chronic sexual, physical and emotional abuse or neglect in childhood.

The adaptations and responses women typically develop throughout their lives as a result of chronic abuse are shaped and determined by multiple factors. These factors include gender socialization into traditional notions of femininity, sexism, racism, poverty and other social conditions of their lives. The ways in which women are socialized to internalize these experiences and women’s greater social powerlessness resulting from gender inequality lead to significant gender differences in women’s mental health issues and needs. These differences affect the way in which women’s problems are most typically diagnosed within the mental health system.

Despite these differences, there is often little recognition or understanding in the literature on trauma treatment and theory of the actual conditions of many women’s lives or of the effects of gender inequality, sexism, female socialization, class and race that influence women’s psychological development. In other words, most trauma theory ignores the role of gender. Yet a failure to take these factors into account leads to a failure not only in understanding the mental health issues women face, but in providing effective therapeutic interventions.

THE IMPACT OF GENDERED VIOLENCE AND ABUSE IN WOMEN’S LIVES

Experiences of sexual violence and abuse in women’s lives instill lessons in, and reinforce, what it means to be female in this society — that is, being relatively disempowered and with compromised or non-existent rights to autonomy and bodily integrity.

The pervasive problem of men’s violence in our society, combined with experiences of gender inequality, often reinforce the earlier incidents of

threat and danger inherent in the experiences of childhood abuse. Early experiences of sexual violation teach female abuse survivors lessons about betrayal, physical and emotional danger and what it is to be dominated. Even women who have not been sexually abused share the reality of living in a society where there is gender inequality and potential for male sexual and physical violence. Indeed, this is an element of gender inequality itself.

Revictimization

Even after an abuse experience ends, experiences of violation and fear are often present for women throughout their lives, by virtue of living in a society in which violence against women and children is pervasive. The phenomenon of **revictimization** — multiple experiences of sexual violence, as well as the increased vulnerability to further sexual violence, resulting from an early experience of child sexual abuse — is a far greater problem in women's lives than is acknowledged in the literature (Haskell, 1997). In her book *Trauma and Recovery*, Judith Herman (1992) describes coercive control as a major cause of complex post-traumatic stress. She asserts that prolonged, repeated trauma typically occurs in families and in other relationships in which the woman is unable to flee because she is under the control of the perpetrator.

Feeling trapped and powerless is a natural response to being subjected to a perpetrator's control and abuse of power. Many women and children who are abused may be trapped and rendered powerless in physical, economic and psychological ways. The responses to coercive control are numerous, including accepting the perpetrator's worldview that legitimates the abuse; feeling dissociated; losing faith or hope; withdrawing socially or becoming isolated; and feeling self-hatred.

The cause and treatment of complex post-traumatic stress cannot be meaningfully discussed without understanding how socially constructed gender and gender inequality (in which women are seen as having a lesser social value) are entwined with the experience of being traumatized.

Feelings of disempowerment don't end when survivors are free of their childhood abusers. Rather, gender inequality, racism and poverty render many women less powerful, less valued and with fewer resources available to them — as well as at the mercy of others — throughout their lives. These broader structures of social disempowerment typically shape and intensify a

woman's reaction to being abused, exacerbating feelings of powerlessness and vulnerability.

Pearlman (2001) argues that contemporary society questions the reality and pervasiveness of childhood sexual abuse, does not acknowledge that people suffer for years after active abuse has ended and does not believe that people often struggle to remember their abuse. She explains that this discounting and disbelief of the reality of sexual abuse are further evidenced by the fact that our society does not want to pay for treatment for abuse survivors. This fact is made visible by the inadequate provision of services for abuse survivors, especially longer-term treatment that is often needed for the resolution of severe abuse.

Pearlman (2001) also claims that these victim-blaming beliefs have widespread cultural influence. Women who have experienced abuse encounter comments that they “should forget about what happened and get on with their lives” and that “people cause their own miseries.” The media have responded to the increased attention to abuse by claiming that we are becoming a “society of victims.”

Pearlman (2001) argues that misogyny, patriarchy, racism and homophobia must be taken into account therapeutically. In her words, “these are very real, integral aspects of each of our lives, of the context in which our clients were traumatized, and of our psychotherapies with survivors” (p. 209).

UNDERSTANDING ABUSE AND TRAUMA DEVELOPMENTALLY

Part of the conventional approach to working with abuse survivors is to address their feelings of self-blame. Many therapists repeatedly tell abuse survivors that the abuse is not their fault and that they are not responsible for what was done to them. However, they may never provide women with the information they need to develop an alternative explanation of who *is* responsible. To do this, therapists need first to explore with survivors why they think they are responsible for the abuse perpetrated against them as children. It also involves shifting the responsibility for abuse and violence to where it belongs — onto the perpetrators and the society that produces these abusers.

Childhood abuse and the accommodation syndrome

Mental health professionals need to understand children's reactions to child abuse from a developmental perspective in order to reframe clients' narratives of their abuse experiences and correct any self-blaming distortions. The nature and persistence of responses may reflect the ages and developmental stages at which the traumatic event occurred. Incest perpetrated against a child at age four may influence development, experience and functioning in ways that differ significantly from incest perpetrated against a child at age 14.

Therapists also need to be familiar with the adaptive ways that children respond to abuse. An extremely useful conceptual model is the accommodation syndrome (Summit, 1983), which explains children's most typical reactions to dealing with sexual, physical and emotional abuse.

Without requiring survivors to discuss any details of their childhood experiences, the therapist can explain the normal responses that children often have to experiences of abuse and how these coping behaviours lead to subsequent behavioural and psychological problems, including post-traumatic stress. The accommodation syndrome is also helpful in providing a framework to explain the way in which children are developmentally shaped by the experiences of early abuse and neglect. The syndrome captures the complex ways in which the abused child is often made to believe she is complicit in her own abuse.

THE ACCOMMODATION SYNDROME CONSISTS OF FIVE CATEGORIES OF RESPONSE TO AN ABUSE EXPERIENCE (SUMMIT, 1983). THESE INCLUDE:

1. secrecy
2. helplessness
3. entrapment and accommodation
4. delayed, unconvincing disclosure and
5. retraction of the disclosure.

The responses outlined in the accommodation syndrome become entrenched in a child's experience, particularly with intrafamilial violence or when the child has neglectful, unempathic caregivers. The categories describe and explain, from a child's perspective, how the adult's failure to

intervene or acknowledge the abuse results in the child dealing with the trauma as an essentially intrapsychic event. As a result, the child internalizes guilt, self-blame, pain and rage.

The accommodation syndrome also explains how the coping behaviours that children typically use to survive the abuse tend to isolate them. In other words, the very ways in which children might cope with the abuse — for example, by acting out — serve to stigmatize them, thereby compounding their difficulties.

Therapists need to understand each child's perspective of her experiences of inescapable, persistent abuse and neglect to be able to clearly explain and help the child understand the development of traumatic adaptations. Many people still believe that a traumatic event has to be an "objectively" life-threatening event to meet the diagnostic criteria for PTSD. Recent changes in the DSM-IV criteria of what constitutes a traumatic experience, however, reflect an increased understanding that what constitutes a traumatic event relates to the individual's own subjective experience of being threatened or overwhelmed and trapped. By definition, all children who are abused are overwhelmed and trapped. These feelings are compounded further if their abuser is also their caregiver, especially a parent or parent figure.

SEXUAL ABUSE IN CHILDHOOD AND THE EFFECTS ON WOMEN'S ADULT SEXUALITY

One of the often-unrecognized long-term effects of sexual abuse and violence in women's lives is the harmful effect on their sexuality. For some women, one of the long-term effects of sexual abuse in childhood is that their adult sexuality — including both sexual feelings and sexual attitudes — was developed in a distorted way, as a direct result of the confusing and abusive sexual violations they experienced.

When abused as children, many little girls are given special attention, privileges and even affection from their abusers, which is part of the process of their sexualization. This is obviously confusing — being sexually abused while also being treated as "special," being favoured, and being rewarded for being sex objects that exist for the gratification of adult male sexual perpetrators. This dynamic sends deeply distorted messages about sexuality and leads to what is often a life-long and conflicted relationship to a woman's

own sense of her sexuality. The dynamic is particularly acute when the perpetrator is a girl's own father (or father figure) or another close and trusted family member.

Some women who were sexually abused as girls have learned that sexual behaviour is an extremely effective way to receive male attention. They may have come to believe that they are of value only when they are being treated as the objects of male sexual attention, which is too often intrusive and/or coercive.

Social reinforcement of sexuality

This same kind of lesson is reinforced in a society that obsessively emphasizes that women should be “sexy” and “sexually attractive” to men and should spend a great deal of their time and energy on their bodies and clothes in pursuit of this goal. As a result, some sexual abuse survivors develop a heightened sexualized manner and appearance as a way to feel noticed and valued.

Unfortunately, women who experience sexual abuse in childhood often experience further abuse and exploitation in their adult sexual relationships with men — a phenomenon known as revictimization. To compound the problem, these women abuse survivors are then often blamed for the ongoing victimization they experience because they are labelled as “promiscuous” or sexually inappropriate.

Unfortunately, many people do not understand that this sexual behaviour is an adaptation to early childhood experiences of sexual violation and that this behaviour is then reinforced by our sexist society, in which far too many men have learned to be sexually coercive and/or violent.

Part of the clinical work with abuse survivors entails understanding how **traumatic sexualization** (the distorted shaping of a child's sexuality in developmentally inappropriate ways) and difficulties with sexuality are effects of child sexual abuse.

Clinicians need to understand the larger social context within which abuse occurs: a sexual double standard for men's and women's behaviour, a denial of women's sexual autonomy (rights to bodily integrity) and a socially produced femininity that is geared toward over-valuing male attention and approval. Sensitivity to these issues is a necessary part of the landscape for

providing effective therapeutic support to women abuse survivors with post-traumatic stress.

THE LIMITATIONS OF TRADITIONAL PSYCHIATRIC DIAGNOSES IN UNDERSTANDING ABUSE-RELATED POST-TRAUMATIC STRESS

Many traditional psychiatric and psychological categories and approaches are not gender sensitive and do not account for or address the ways in which abuse and trauma factor into women's lives and shape women's mental health issues. Judith Herman (1992), for example, argues that current psychiatric categories are not constructed in a way that adequately reflects the experiences of survivors of extreme trauma.

Multiple diagnoses and pathology

Many trauma survivors who have sought mental health services have been given multiple diagnoses such as bipolar disorder; schizophrenia, paranoid type; and borderline personality disorder. These diagnoses are descriptive labels for "symptoms" and behaviours that emphasize pathology.

Traditional diagnoses like these typically fail to consider the contexts (the traumatic event/s) in which a person may have developed these responses. In other words, many mental health "symptoms" that women exhibit represent their intuitive and automatic attempts to cope with and adapt to traumatic stress, often stemming from prolonged abuse experiences. Traditional psychiatric diagnoses tend to focus on what is "wrong" with the woman, rather than recognize the ways in which she has reacted to and coped with traumatic events in her life.

Until recently, most mental health professionals failed to understand these problems as part of a spectrum of complex, psychological and physical responses to multiple traumas across a lifespan. Instead, these problems were considered to be co-occurring conditions (van der Kolk, 2001). For example, it is not unusual in a traditional psychiatric setting for a woman to be diagnosed with major depression, panic disorder, borderline personality disorder and a chronic pain disorder with medical and psychological features, without any connection being made between her responses, the mental health issues she exhibits and her earlier experiences of abuse and/or neglect.

The consequences of multiple diagnoses

Not understanding the chronic and complex psychological harm done to abuse survivors has serious consequences for the adequacy and effectiveness of therapeutic treatment. Survivors end up getting treated for an array of “symptoms” and problems as they fit into existing diagnostic categories, without their problems being linked to the traumatic events to which they were responding.

The result is not only a fragmented approach to treatment (Herman, 1992, p. 119), but also the potential for inappropriate treatment because the underlying issues of trauma and neglect have not been identified and addressed. Thus, abuse survivors may not be provided adequate symptom relief and may suffer the additional consequence and possible humiliation of being considered “treatment-resistant” or “difficult patients.” This kind of labelling compounds the problem and stigmatizes the women whose lives have been harmed by experiences of abuse.

ABUSE, VIOLENCE AND COMPLEX POST-TRAUMATIC STRESS

Many of the women who have experienced violent or traumatic events in their lives clearly suffer severe and devastating effects. However, the developmental, emotional and psychological consequences caused by violence and trauma, especially originating in childhood, are frequently underestimated and misunderstood by mental health professionals. The complexity of responses has not been fully understood, in part, because the acts of childhood physical and sexual abuse are so abhorrent that these events in themselves have often been thought to create most of the long-term effects.

The context of neglect

It is now better understood that child abuse often happens in a context of severe neglect, emotional invalidation and deprivation (Briere, 1996; Chu, 1998). The effects of emotional and physical neglect are now recognized as contributing to the long-term emotional and psychological difficulties many abuse survivors experience. Neglect may mean not having a parent who is attuned to and aware of the child's emotional feelings and needs, not being protected and experiencing repeated loss and separation.

The effects of trauma on development

Cognitive, affective and psychosocial development are shaped and affected by a combination of chronic abuse, lack of emotionally connected parenting and/or the deprivation of basic childhood needs such as safety, parental constancy and emotional validation.

Women who grow up with childhoods characterized by abuse and neglect very often struggle with a host of psychological difficulties. They may have a distorted sense of self, trouble forming and maintaining relationships, an inability to regulate their emotional responses (affect dysregulation) and a belief that people are not safe and should not be trusted. They may also develop substance use problems and engage in other forms of self-destructive behaviour.

These trauma-related processes result in inadequately developed **self-capacities**. Self-capacities are the inner abilities that allow people to manage their intrapersonal worlds and maintain a coherent and cohesive sense of self (McCann Pearlman, 1990). The three self-capacities considered especially important to the individual's response to aversive events are identity, boundary and affect regulation (Briere, 1996).

Identity

Identity refers to a stable sense of self and a consistent internal locus of conscious awareness (an ongoing conscious awareness of self). A strong sense of identity allows an individual to face adversity from a secure internal sense of self. Briere (1996) explains that people with a less stable identity may **fragment** when they most need to have an awareness of their own needs, perspective and entitlement.

Boundary

Boundary refers to an individual's awareness of the distinction between self and other (Briere, 1996). People with poorly developed boundaries have difficulty determining what their own needs and perspectives are, and what are those of the other person. This can result in either allowing others to intrude on them, or in their intrusions upon others (Elliott, 1994).

Affect regulation

The third self-capacity is **affect regulation**, which is the ability to experience, tolerate and integrate feelings (Pearlman, 2001).

Abuse survivors with inadequately developed self-capacities rely on **dissociation** or other external ways of dealing with painful internal experiences. Unfortunately, these attempts to deal with overwhelming pain are not effective in the long term. Women often seek out therapy or help when the adaptations begin to lose their effectiveness.