

2005

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Recommended Citation

Stalker, Carol; Harper, Kim; Palmer, Sally; and Gadbois, Susan, "Experiences of adults abused as children after discharge from inpatient treatment: Informal social support and self-care practices related to trauma recovery" (2005). *Social Work Faculty Publications*. 1.

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Experiences of Adults Abused as Children After Discharge From Inpatient Treatment: Informal Social Support and Self-Care Practices Related to Trauma Recovery

Kim Harper, Carol A. Stalker, Sally Palmer, & Sue Gadbois

ABSTRACT

This qualitative study explored adults' perceptions of experiences that were helpful and unhelpful to their recovery from the traumatic effects of childhood physical and sexual abuse. The authors conducted in-depth interviews with 30 participants approximately 6 months after discharge from an inpatient trauma treatment program. Participants reported that barriers to recovery postdischarge were lack of follow-up support immediately after discharge, social isolation, lack of friends, problems with partners, and lack of emotional support from family members. Facilitating factors were concrete support from family and friends; emotional support, particularly from friends; developing a social network unrelated to the abuse history; and continuing self-care strategies learned in the inpatient program. Implications for community-based mental health professionals are discussed.

Experiences of childhood physical and sexual abuse have been associated with many difficulties in adulthood, including depression, anxiety, and personality disorders (Ellason & Ross, 1997; Ellason, Ross, Sainton, & Mayran, 1996; Ogata et al., 1990; Ross-Gower, Waller, Tyson, & Elliott, 1998). Studies have also found that experiences of childhood abuse have been associated with the increased risk of chronic post-traumatic stress disorder (PTSD) in adulthood (Schaaf & McCanne, 1998; Widom, 1999). Furthermore, survivors of childhood abuse often experience problems with the development of long-lasting relationships (Cosden & Cortez-Ison, 1999; Crouch, Milner, & Thomsen, 2001; Litty, Kowlaski, & Scott, 1996)

and the ability to care for the self (Bills & Bloom, 1998; Leenerts, 1999; Warren, 1998).

Specialized trauma-focused inpatient programs have been developed in an attempt to improve outcomes for this population. Common treatment approaches used by these programs include "attention to issues of personal safety ... skills-building for self-management and symptom reduction ... and the reintegration of the individual into everyday family, work, and social life" (Courtois & Bloom, 2000, p. 201). Research has suggested that, although participants tend to improve considerably during an inpatient stay, a significant proportion is likely to deteriorate after discharge to the home community (Courtois & Bloom, 2000). Most

follow-up studies, however, have focused on veterans, and because childhood abuse is fundamentally different in nature than experiences of war, it cannot be assumed that the results would be the same. The limited research focusing on inpatient programs for adults abused as children has found longer term maintenance of treatment gains (Allen, Coyne, & Console, 2000; Ellason & Ross, 1997; Stalker, Palmer, Wright, & Gebotys, in press; Wright & Woo, 2000).

Few studies have focused on factors that contribute to childhood abuse survivors' sense of well-being after inpatient treatment. Little is known, for example, about the types of aftercare programming provided or how survivors of childhood abuse use the skills learned in the inpatient programs when they are discharged to the community. The purpose of the current research was to examine, from the perspective of adults who were physically and sexually abused as children, what was most and least helpful in contributing to their recovery in the 6 months after inpatient trauma treatment.

Inpatient programs for survivors of childhood abuse focus on helping survivors to develop social support networks (Courtois & Bloom, 2000). Social isolation is problematic for many adults abused as children. Studies have found, for example, that women who experienced childhood sexual abuse tend to have fewer social supports in adulthood (Buist & Janson, 2001), and the more severe the abuse, the greater is the social isolation (Gibson & Hartshorne, 1996; Leitenberg, Greenwald, & Cado, 1992). Adults physically abused as children, compared with those who did not report abuse, also tend to have more difficulty developing close, long-lasting relationships (Litty et al., 1996). Yet researchers have found that positive experiences of current support from family and friends can be protective against lasting psychological distress for adults physically and sexually maltreated as children (Banyard, 1999; Muller & Lemieux, 2000; Runtz & Schallow, 1997).

Understanding the role of supportive adult relationships in trauma recovery is complicated because abuse survivors' perceptions of the types of support they receive tend to vary. Muller, Goh, Lemieux, and Fish (2000), for example, found that adults physically and sexually maltreated as children reported that their friends were the most important providers of all types of social support, ahead of their mothers, siblings, partners, and professionals. Feiring, Taska, and Lewis (1998), alternatively, found that support from friends was important to adolescent girls who were sexually abused as children, but it was only related to better adjustment when parents were also supportive.

Inpatient trauma programs also focus on helping survivors of childhood abuse to develop self-care strategies (Courtois & Bloom, 2000). The literature has also linked inadequate self-care strategies to childhood histories of abuse. Leenerts (1999), for example, studied the intrapersonal and interpersonal patterns of behavior that influenced self-care practices in low-income White women living with HIV/AIDS who were physically or emotionally

abused as children. She found that child abuse survivors tended to disconnect from self-care because they had developed traumatized self-images and confused self-other images. Warren (1998) studied the self-care capacities of pregnant low-income adolescents who were physically abused and neglected and found that "self-care is directly related to knowledge about health, personal strengths, and the amount of control individuals have over their personal health" (p. 34).

This study focuses specifically on social support and self-care strategies developed during the inpatient trauma program. We define social support using relevant components of the multidimensional construct described by Cameron (1990). He distinguished among concrete support (i.e., providing material aid), emotional support (i.e., intimate caring, acceptance, or encouragement), and social integration (i.e., the provision of an enduring social network and sense of affiliation). Our definition of self-care strategies is similar to that offered by Leenerts (1999); she defined self-care as "self-described behaviors" used "to promote or improve" (p. 382) physical, emotional, psychological, and spiritual health. From the resulting data, we draw conclusions about how social workers and other helping professionals in community-based agencies can more effectively support adults with histories of child abuse.

Method

The sample for this research was recruited from a larger study of 163 men and women who were consecutively admitted to the Program for Traumatic Stress Recovery (PTSR) between September 1998 and February 2000. The PTSR is a 6-week inpatient treatment program for adult survivors of various traumatic experiences. All participants in the larger study reported a history of childhood abuse (physical, sexual, and/or emotional), signed a consent form agreeing to participate after hearing a complete description of the study, and completed the 6-week inpatient program.

Participants in the larger study were asked to complete self-report questionnaires at five points in time (admission, discharge, and 3, 6, and 12 months postdischarge). They completed additional questionnaires used in a previous study to give information about demographic background and abuse history (Palmer, Brown, Rae-Grant, & Loughlin, 2001). Abuse history was also obtained from the Trauma Assessment for Adults–Self-Report (Resnick, Best, Kilpatrick, Freedy, & Falsetti, 1993), which assesses the severity of the trauma related to lifetime exposure to any of 14 categories of traumatic events. Standardized outcome measures included the Modified PTSD Symptom Scale (Falsetti, Resnick, Resnick, & Kilpatrick, 1993), the Traumatic Stress Institute Belief Scale–Revision L (Pearlman, 1996), and the Global Severity Index of the Symptom Checklist (SCL-90; Derogatis, 1992).

The 30 participants in the study reported here were selected from the original sample of 163 individuals who

indicated their willingness to be interviewed on a pretreatment questionnaire. Those selected lived within 2 hrs driving distance from the hospital. Nearly 95% of those contacted agreed to be interviewed and signed informed consents.

Our 30 participants completed qualitative, open-ended, semistructured interviews between 6 and 8 months after discharge from the inpatient program. Master's-level social work students were trained to conduct the interviews, which ranged from 1 to 1.5 hrs in length. The goal of the interview was to understand the relevant experiences of participants from their own perspectives. Participants were asked to identify what was helpful and not helpful to their social, emotional, and psychological well-being and the nature of their interpersonal relationships since discharge. There was a general interview guide, but the focus was on what was important to the interviewee. Interviews were conducted in the participants' homes.

The interviews were audiotaped and transcribed, and two doctoral-level social work students completed the data analysis. Data analysis began with the first interviews and was used to inform and modify the ensuing interview process. An ethnographic approach (Fetterman, 1989) was used, and the four authors worked together to develop codes and themes. Constant comparative analysis was done to further delineate themes and identify common and unusual dimensions (Strauss & Corbin, 1998). The interviews were coded with the assistance of the NUD*IST (Non-numerical Unstructured Data-Indexing, Searching and Theorizing, 1997) software package. The first three interviews were coded independently, initial themes were discussed and agreed on, and subsequent transcripts were coded by only one coder. The two doctoral students met regularly to compare themes and dimensions as they emerged and to ensure that there was agreement about the fit with the data.

Inpatient Trauma Program

The PTSR is a specialized inpatient program serving self-identified adult survivors of trauma at a semiprivate hospital in a small Ontario (Canada) city. Most participants have been physically and/or sexually abused as children. This 6-week residential program, an adaptation of Bloom's (1997) sanctuary model, attempts to create physical and emotional safety within a therapeutic community, assuming that healing takes place within relationships. Most of the treatment is delivered in group settings by a multidisciplinary team, including psychiatry, psychology, nursing, occupational therapy, social work, recreation therapy, creative arts therapies, horticulture therapy, and pastoral care. A focus of the program is creating physically and emotionally safe relationships within the residential setting and transferring these skills to relationships in the community. Staff encourage participants to find support in the community before exiting the program (Wright & Woo, 2000). Because participants come from across Canada, the program does not provide formal aftercare, although the development of

self-help groups in nearby communities is encouraged. Participants are also encouraged to develop self-care strategies that can be continued after discharge.

Results

Table 1 displays the demographic characteristics and abuse histories of the 30 participants who were interviewed. The majority were female (83%) and ranged in age from 20 to 54 years. Participants were generally well educated; 83% had completed at least some university or college. Most were married or living with a partner (65%) and employed (37%) or on sick leave from work (40%) at the time of admission to the program. Three participants identified themselves as members of minority groups: Aboriginal and bisexual, Latin American, and Japanese Canadian.

All 30 participants reported physical or sexual abuse, or both, and 29 (97%) reported that they feared that they might have been killed or seriously injured or that they were physically injured during at least one traumatic event. Twenty-seven (90%) were abused by their mother or their father, or both, and some of these reported abuse by another person as well. Of the 3 participants (10%) who did not report abuse by their mother or father, 2 (7%) were abused by brothers and 1 (3%) by a teacher.

Four participants (13%) had been clients at the PTSR before this admission, and 26 (87%) previously sought help for problems related to the abuse. On admission to the program, Axis II disorder diagnostic evaluations were conducted for 16 (53%) of the 30 participants. Six of the 16 participants (38%) did not have Axis II disorders, 9 (56%) had one diagnosis, and 1 (6%) had two or more. The principal Axis II diagnoses were as follows: avoidant ($n = 4$; 25%), obsessive-compulsive ($n = 3$; 19%), paranoid ($n = 2$; 13%), and borderline personality ($n = 1$; 6%). Data from the SCL-90 at admission indicated that 10 (33%) of the 30 participants reported having some thoughts about injuring or harming someone, 20 (67%) reported thoughts of death or dying, and 25 (83%) reported feeling hopeless about the future.

Although the PTSR does not provide a formal follow-up program, data from the interviews indicated that all of the 30 participants were receiving outpatient postdischarge therapy on their own initiative, and many were seeing more than one professional; 13 (43%) saw one professional, 11 (37%) saw two, 2 (7%) saw three, and 4 (13%) saw four. Participants discussed receiving professional help from psychiatrists (16 [53%]), therapists-counselors (10 [33%]), family doctors (9 [30%]), group therapy led by professionals (6 [20%]), social workers (5 [17%]), mental health support workers (5 [17%]), other professionals (4 [13%]), and crisis workers (2 [7%]).

The larger study found that, as a group, the participants who received inpatient treatment were significantly improved on the standardized outcome measures at discharge, 6, and 12 months follow-up. However, a substantial

TABLE 1. Demographic Characteristics and History of Abuse

VARIABLE	RANGE	M	%
Age (years)	20–54	40.8	–
Gender			
Female			83
Male			17
Education			
Less than high school			7
High school graduate			10
Some college or university			24
College or university graduate			52
Postgraduate studies completed			7
Employment status at admission			
Employed full- or part-time			37
On sick leave			40
Unemployed			13
Other (homemaker, student)			7
Missing data			3
Marital status			
Married or living with partner			65
Single			7
Separated or divorced			28
Member of minority group			
Aboriginal and bisexual			3
Latin American			3
Japanese Canadian			3
Abused as a child			
Physically and sexually			67
Solely physically			20
Solely sexually			13
Traumatic events			
Feared being killed or seriously injured, or was seriously injured, during at least one traumatic event			97
Perpetrator(s)			
Mother, father, and at least 1 other person			30
Mother and at least 1 other person not the father			20
Father and at least 1 other person not the mother			20
Mother and father but no one else			3
Solely mother			7
Solely father			10
Solely other person			10

Note. Demographic information was missing for 1 participant. Percentages may not add up to 100 because of rounding.

proportion did not show change in a positive direction at these follow-up points. Between 25% and 30% (depending on the outcome measure) did not show positive change at discharge compared with admission, and between 31% and 39% did not show positive change at 12 months follow-up compared with admission (Stalker et al., in press). Because in the current study we were interested in the lived experiences of those who were struggling with the recovery process as well as those who were improving, the subsample of 30 participants included a larger proportion of individuals

who did not show positive change at discharge or follow-up compared with the larger sample. In this subsample, between 32% and 34% (depending on the outcome measure) did not show change in a positive direction at discharge compared with admission, and between 29% and 46% did not show positive change at 12 months follow-up compared with admission.

However, in contrast to the findings based on the standardized measures, when interviewed approximately 6 months after leaving the program, all 30 participants expressed the belief that they were making at least some progress in their recovery. Many stated that they found it very difficult to leave the inpatient program, but by 6 months postdischarge they all stated that they were improving again.

Unhelpful Experiences

Nearly all those interviewed discussed problems that arose because of the lack of follow-up support after leaving the inpatient program. Additionally, many discussed problems connecting to people outside the hospital. Some participants noted that they tended to isolate themselves as a coping strategy after discharge. Many reported a paucity of friends, difficulties with partners, and lack of emotional support from the family of origin.

Lack of follow-up support immediately after discharge.

The majority of participants talked about the difficulties they had immediately after discharge. It was problematic for many participants when they returned to the community without any follow-up support from the inpatient program. One woman stated, for example, “I left [the hospital] feeling like ‘Okay, guys, you’ve opened the door, you’ve got me feeling, I’m raw with feeling and I don’t know what to do with it.’ And at about 3 months out of the program, I was in total, complete panic.” Other participants talked about experiencing, on leaving the program, “nervous breakdowns” and depression. Some reverted to previous coping strategies such as isolation and self-harm.

Isolation as a way of coping. A number of participants stated that, on leaving the program, isolating themselves from others as a way of coping with their feelings was problematic. One woman said, “I isolate when I’m down. I don’t want people to see me when I’m like that.” Another woman remarked, “When I first came home, I tended to want to be very isolated. I didn’t really want to go out and see people or talk to people and I had to really fight that because it could have been a really big problem.” Another woman who discussed this issue, however, talked about times when isolating herself felt helpful, such as when she was canoeing in the wilderness. Using isolation as a way of coping was only unhelpful to her when she felt that she was not using her time well: “when I’m watching TV [or] eating junk food.”

Absence of friends. More than half of the participants, although they might have identified some connection to a partner or family member, described feeling socially isolated because they had lost all their friends. One man

remarked, “Most of the friends I had growing up have gone their own ways, moved away.... I didn’t have a whole lot of friends to start with, but I haven’t got any around here anymore.” A woman stated that she could not maintain friendships with people because they continued in a lifestyle that was no longer desirable for her: “I don’t have any friends I can go out with now because they all drink.” Some participants, however, who discussed the loss of friends also talked about having some friends; they tended to describe them, however, as providing a social network as opposed to providing emotional support. A man noted, for example, that he went to his son’s baseball game to “sit with any of the parents” and a woman noted that she played cards with people.

In contrast, those who did not discuss the issue of losing friends often described friendship-type relationships that were emotionally supportive and helpful to their recovery process. One woman, for example, appreciated the support she received after discharge from friends she made at the hospital; another described emotional support she received from her “best friend” and from a women’s group she had joined; a third discussed the emotional support she received from her in-laws; and a fourth person appreciated the emotional support of her Alcoholics Anonymous sponsor.

Difficulties with partners. After discharge from the trauma treatment program, more than half of those participants who were married or living with partners noted difficulties in these relationships. Some participants explained that their partners did not understand the changes they had made in the program or did not understand the trauma recovery issues with which they were dealing. One participant, for example, learned during the program to pace herself and take care of her own needs first. When she came home, therefore, she did not worry about the housework like she had before, which upset her husband. With reference to her husband she said, “To keep him happy would have meant pushing myself [to do the housework], which I knew if I did, I was going to be back at square one. So, I just kept explaining to him ... and some days just blowing up. He’d back off and then he’d come back again a couple of weeks later [saying] ‘I don’t understand this. You’re driving me nuts.’ And I had to just keep [explaining].”

Furthermore, some participants did not anticipate when they left the program that their partners would not have changed. A female participant stated, “It was a shock coming back out to the world because I had changed, but nothing else had changed.... Like my spouse doesn’t know exactly what went on in the program. I shared as much as I could, but ... you kind of expect when you change, things [will] change around you.”

Moreover, some participants reported very difficult experiences in their relationships with partners. One man, for example, stated that his wife “told me while I was in the program, on about the third week, that she wanted a separation.... I just thought, how insensitive could anybody be

in the midst of someone being in a hospital.” Another woman’s husband had sexually abused their daughter, and another woman’s ex-husband, at the time of the interview, was threatening her life.

Some participants, however, although finding it very difficult to return home to unhappy relationships with their partners, talked about their decisions to stay in these relationships. A man stated, “I hate my marriage ... I am very loving, very romantic, but it’s just ... the role, that’s my mask ... and the thing is that if I try to leave, I can’t because [of the] shame.” A woman stated that her partner “has been the least helpful person,” but she stays with him because “I strongly believe that I will learn how to respond differently ... I’m married, and I’ve taken it very, very seriously.”

Lack of emotional support from parents and other family members. Partners, however, were not the only people who were perceived as unsupportive around the issues of recovery from childhood abuse. More than half of the participants also noted that parents and other family members were sometimes unsupportive. Some participants discussed difficult relationships with their parents, particularly with their mothers. Eighteen participants reported childhood abuse by their mothers. As expected, more participants who reported abuse by their mothers (50%) than those who did not report abuse by their mothers (17%) made only negative comments about these relationships. Those abused as children by their mothers tended to perceive their mothers as demanding or dismissive in the present. Many remarked that their mothers were intimidating, intolerant, or unsupportive or had abandoned them. Those not reporting abuse by their mothers, alternatively, noted that their relationships with their mothers were problematic because their mothers did not understand depression issues or trauma recovery. One woman, for example, stated, “My mom has a particularly hard time dealing with this. She just does not understand it. She’s never been depressed a day in her life and she really doesn’t understand why [I get depressed].” These participants seemed to indicate that their mothers did not understand what they were experiencing as opposed to feeling personally rejected by them.

Helpful Experiences

Nearly all of the participants noted that concrete support, emotional support, and/or developing a social network that allowed them to acquire a sense of self apart from the abuse were helpful in their recovery process. Practicing self-care skills that they learned during the trauma program was also discussed as being helpful by more than half of the participants. Thirty-three percent of those not reporting abuse by their mothers compared with 11% of those reporting abuse by their mothers discussed helpful experiences in these relationships. The 2 participants who reported child abuse by their mothers discussed receiving emotional support from them but did not discuss concrete support.

Concrete support. Approximately half of the participants noted that their mothers, parents, in-laws, and/or

friends provided practical day-to-day support that made it easier for them to continue their recovery process after discharge from the trauma program. The mother of 1 participant, for example, made her meals and took care of her when she could not care for herself. Another participant's in-laws provided child care whenever she needed it. A third participant noted that, although her parents were not supportive around the abuse, they would provide financial support whenever she needed it. Other participants noted that friends provided them with places to stay when needed, helped with moving, and ran errands.

Emotional support. The majority of participants said that emotional support was helpful to their healing process. Of those who discussed this issue, friends were named by more than half as an important source of emotional support; 20% mentioned partners, and very few named mothers, siblings, children, and coworkers in this category. Friends were helpful when they would listen to participants and validate their feelings. One woman stated, "My friends remained supportive ... they try to be understanding. And, they listen....And, for the daily things of life that wear you down, you have someone to talk [with] about them.... And they can say ... 'I know what you're feeling.'" Another participant said that her best friend talks to her about "how she was proud of me for doing it [trauma treatment] and for some of the changes that she has seen."

Friends whom participants met through the inpatient trauma program were seen as emotionally supportive because their experiences were similar, they had deeply personal knowledge about each other, they used the same terminology, and they understood when another person was having a difficult time. Furthermore, participants noted that they never had to explain themselves to these friends because others from the program experienced similar feelings. Friends who were not from the inpatient trauma program but had experienced similar problems, such as depression or alcoholism, were also perceived as emotionally supportive because they knew what the participant was going through.

Although only 6 participants (30% of those married or living with partners) talked about emotional support from their partners, most of them only had positive things to say about the support they received. The same was true when participants discussed emotional support from children and coworkers. Those who spoke about emotional support from mothers, however, tended to qualify their statements. Of those who had reported experiencing child abuse from their mothers, the emotional support was often discussed as a new or unusual experience, which occurred at the initiative of the participant. A woman stated, for example,

My doctor was trying to find a convalescence facility for me because she knew I was coming home alone and when my mother heard about that she said "we'll [mother and father] come and stay with you."... And it worked out really well; it gave us an opportunity to talk

... and to get to know them again. So I really appreciated the fact that they were there and I was asking for help, which I had never done before.

The only participant who identified her mother as emotionally supportive and who did not report childhood abuse by her mother remarked that her mother had always been supportive.

Social integration. Nearly half of the participants noted that developing a social network apart from the abuse was very helpful to their recovery process. It was important to participants to partake in everyday activities. One woman spoke about the pleasure she experienced from interacting with other dog owners: "It gets me out of the house and it gets me interacting with people, and I find that people who usually have dogs and go to these shows are usually nice people.... I have a lot of fun." Others talked about connecting with groups of friends who have similar interests, such as going to the theatre or playing cards. A woman describing a workshop for artists summarized by noting, "I found it really helpful because it's a great networking thing. And then you find out from other people that you can do things too."

Self-care. Participants used self-care activities in many different ways to enhance their sense of well-being. Some used self-care activities, for example, for self-expression and relaxation. One woman stated, "When I can't talk, I can often paint, because words don't come out and I can't write it sometimes. But I can paint it or draw [it]." Another woman said, "Journaling is very helpful ... It's a private thing and it takes all the crap that's in me and puts it on paper and I put it away. That's crap I don't have to carry around at night before I go to bed. And I always say, 'Okay, now I've done this ... I'll sleep well tonight.'" A man remarked, "Music soothes me. Music calms me down. Music makes me think."

Some participants used self-care to take a break from social interaction. One woman remarked: "So, I'm swimming 3 days a week, and it's excellent. It's really good because I've noticed different things when I'm there, like I don't have to socialize with anybody and that's fine." For others, activities such as reading, gardening, music, and art allowed them to care for themselves without feeling guilty about not socializing. One woman said, "Sometimes ... I'll take my lawn chair or blanket and I'll go to the park ... and read ... just try to get away from things." Another woman speaking about gardening, sewing, and reading stated, "It lets me isolate without having to say 'Oh, I'm isolating in a bad way.' I think it's a good thing for me."

Discussion

Many participants in this study felt that they needed follow-up support from the inpatient program immediately on discharge. They had experienced a great deal of support from staff and other participants during the 6-week

inpatient program but found this support difficult to replicate at home or in the community. The dramatic reduction in easily accessed support was experienced as a painful loss. These findings suggest that immediate and continuous follow-up from the program after discharge could reinforce what participants learned in the program and help them to maintain the gains they had made rather than experience a disturbing increase in symptoms and dysfunctional behaviors. The development of follow-up services for clients in their home communities, or by telephone if home communities are too far from the hospital, was recommended by many participants to facilitate the transition home and the transfer of what they had learned in the program to the community environment.

Participants' perspectives on the issue of isolation were somewhat unexpected. Although some stated that reverting to the use of isolation as a coping mechanism when they left the program was problematic, others noted that being alone could be helpful if they were engaged in constructive activities. Solitary self-care activities, for example, were not only helpful to the recovery process but also allowed them to be alone without feeling guilty about isolating themselves. When solitary activities were perceived as self-care, they were often positive. Survivors of childhood abuse tend to isolate themselves as a way of coping with the stress and anxiety they feel when they engage socially (Briere, 1996; Herman, 1992), and many experience depression and PTSD symptoms that limit their abilities to socialize (McFarlane & Yehuda, 1996). The importance of helping survivors of child abuse to reduce their tendencies to isolate in a maladaptive way and to enhance their self-care activities is emphasized in the literature (Herman, 1992; Matthews & Chu, 1997). It is important to recognize, however, that, at times, being alone can be helpful to recovery, especially if the activity being undertaken enhances a person's sense of well-being. Little attention has been given to understanding the balance between the need for solitary self-care practices and the need to reduce social isolation. Mental health professionals need to avoid condemning all isolation and recognize that individuals differ in their need and use of time alone.

Absence or loss of friends is also an issue worthy of note. Many participants identified the loss of friends on discharge from the inpatient program as problematic. However, it seemed to be a much larger obstacle in terms of self-perceived progress for those who did not have friends at all or for those who saw friends only as part of a social network rather than meeting with a friend on an individual basis. This is important because, for the participants who had friends, the friends were more often seen as emotionally supportive than were partners or other family members. It might be hypothesized, therefore, that the emotional support provided by friends is qualitatively different from that provided by partners and other family members. These findings are in accordance with those of Muller et al. (2000), who theorized that friends were more

important than partners or other family members because they provided self-esteem enhancement, acceptance, and attention to each other's needs. Procidano and Heller (1983) also found a difference in the type of perceived social support from friends and family, which, in part, they attributed to the effect of the duration of the relationship. They also found that perception of family support was related to the level of intimacy with father and mother, which, of course, would be affected by experiences of child abuse.

Many clinicians have noted that the traumatic effects of child abuse often include unconscious reenactments of the abuse in present relationships (Lindy & Wilson, 1994; Walker, 1994). The heightened importance of friends to the recovery process of adults abused as children, therefore, might be further explained in that friends, particularly those who did not have a long-term history with the abuse survivor, might be less likely than a partner or other family member to trigger memories and emotions related to the childhood abuse.

Some participants in this study, for example, who had difficult relationships with their partners expected that their partners would have changed as the participant changed. These unrealized expectations may have been reminiscent of those experienced as a child, when the child hoped that the offender would change but never did. Furthermore, some participants were in extremely difficult relationships with their partners: Some were revictimized by their partners physically and/or emotionally. In addition, a few participants were determined to remain with their partners, even though the relationships were difficult, because of the shame associated with leaving and because they had committed to the relationship. Children in abusive families are helpless to remove themselves from the abusive situation, and the decision to stay in a difficult relationship with one's partner may be a reenactment of the child's feelings of helplessness with respect to escaping the abuse.

Family members, especially those involved with survivors at the time of the abuse, may also evoke childhood reactions to the abuse. Very few participants, for example, who did not report childhood abuse by their mothers described the present relationships negatively. Those who discussed a negative relationship explained that their mothers did not understand what was happening to them with respect to the trauma and recovery. This might have felt like a prolongation of the lack of protection they received as children resulting in the continuation of the childhood feelings into adulthood. On the other hand, the family dynamics experienced in childhood actually may not have changed. Many participants who reported that their mothers were abusive in childhood described their relationship as extremely unsupportive, if not abusive, in the present. Most of these participants noted that their mothers, at the very least, continued to be intimidating or intolerant in adulthood, and some described

them as dismissive and rejecting. It is interesting to note that the 2 participants who reported abuse from their mothers in childhood but expressed feeling emotionally supported by them in adulthood qualified their statements by noting that the mother's behavior was unusual and the interaction was at the initiative of the participant. It would be important, therefore, that helping professionals assess the ongoing relationships between survivors and their mothers to ensure that any abuse has stopped and that the survivor has some power in the relationship. Relationships should not be encouraged between abusive parents and their children until both the survivor and parent have addressed the issues individually.

The positive reports about support from friends appear to reflect the less-conflicted relationships that survivors have with friends compared with partners or other family members. Some said friends were emotionally supportive even when they did not necessarily understand the abuse. In addition, friends who did not know the participant in childhood would not hold the same feelings of guilt and responsibility around the abuse as family members; the support they provide is likely to be experienced as more objective and reasonable to the abuse survivor. It appears that the emotional support provided by friends is difficult to replicate with partners and other family members; the inability to make friends or the loss of friends may, therefore, be a factor affecting the recovery process in a crucial way. Further research is necessary to assess how the effect of friends' support on survivors of childhood abuse may differ from that of partners or other family members and why having support from friends is so helpful.

Mental health professionals in hospital- and community-based agencies should consider how informal social supports and self-care practices may contribute to trauma recovery. For survivors who do not have family, friends, or partners offering concrete support, helping professionals need to recognize the importance of this type of help and facilitate the provision of such support from other sources. Couple therapy designed to help survivors and their partners understand the way in which both can become caught in the reenactment of abuse in their relationships would be helpful in overcoming the stress in these relationships. Couple therapy could also be helpful in assisting survivors and their partners to better understand each other so they can be mutually supportive throughout the recovery process. Thorough assessments should be done, however, to ensure that abuse is not presently occurring because this may contraindicate couple therapy. Family therapy with survivors and family members willing to participate may help all to better understand such feelings as guilt, shame, and loyalty that often interfere with the abilities of family members, particularly mothers, to provide appropriate support. Again, however, a thorough assessment must be done to ensure there is not ongoing abuse in the relationship.

The findings of this study can be seen as supporting the appropriateness of psychosocial rehabilitation services for

individuals suffering from PTSD. Penk and Flannery (2000) include interventions that improve daily living skills, social interactions with family and friends, harm-avoidance/health-promoting behaviors, housing needs, and educational needs in the definition of psychosocial rehabilitation services. Social skills training, for example, although developed to meet the needs of persons with other mental disorders, is "recommended particularly for persons with severe symptoms of social avoidance associated with PTSD" (Penk & Flannery, 2000, p. 235). Clearly, mental health professionals can work with many abuse survivors to identify supportive friends and encourage them to nurture these relationships. Many survivors benefit from encouragement to take calculated risks in reaching out to potential friends. Furthermore, survivors can be encouraged to participate in activities that help them experience themselves as multifaceted human beings rather than solely as abuse survivors.

The findings from this study also suggest that abuse survivors are likely to benefit when mental health professionals encourage them to acquire self-care strategies that will assist them in developing a healthy sense of self and the strength required to navigate the long recovery process. Survivors can be assisted in distinguishing between the use of isolation as a maladaptive coping strategy and positive solitary self-care strategies that can enhance well-being. Survivors who are learning positive self-care strategies after years of self-neglect need support and reinforcement of new ways of thinking and behaving to withstand tendencies to return to more familiar and less adaptive behaviors. Regular, dependable contact with mental health professionals during this time can provide such reinforcement and support.

There are limitations to this study. The research examined the postdischarge experiences of 30 clients from one inpatient trauma program; therefore, the results cannot necessarily be generalized to a wider population. Furthermore, the sample was primarily White and middle class; it is important to explore the experiences of a broader spectrum of people. Nevertheless, this research gives a rare opportunity to gain insight into the post-treatment experiences of childhood survivors of physical and sexual abuse, the nature of social isolation experienced by some, and the types of social support and self-care strategies that they perceived as beneficial.

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Author's note. The Social Sciences and Humanities Research Council of Canada, and the Homewood Foundation, Guelph, Ontario, provided funding for this study.

Manuscript received: October 9, 2003

Revised: August 12, 2004

Accepted: August 19, 2004