

TSS GROUP NEWS



Traumatic Stress Studies Group, Department of Psychology, 2155 S. Race Street, Denver CO 80208
Web: <http://mysite.du.edu/~adeprinc/lab.html> Phone: 303.871.7407



Winter News Highlights

Anne P. DePrince, Ph.D., TSS Group Director

With this newsletter, we are pleased to tell you about the major findings from the Healthy Adolescent Relationship Project (HARP). We thank many of you for your help getting the word out about that study to make it a success! I hope you also enjoy reading about preliminary findings on children’s trauma-related symptoms in relation to parenting variables as well as an upcoming project that will roll out soon. Before you get to those exciting updates, I hope you’ll read below about two ongoing projects for which we are currently inviting participants. Thank you for your help getting the word out!

Please note: Due to university closure for the winter holidays, **our office will close on December 23rd and re-open on January 2.** We will respond to email and voicemail messages received after 12/23 when we re-open.

Getting the Word Out: Women’s Health Project. We are working hard to get the word out about the Women’s Health Project, a collaborative study with the **Sexual Assault Interagency Council (SAIC)** to examine how the sorts of social reactions women receive from others following sexual assault relate to their later well-being and engagement with the criminal justice system. You can read more about the project at <http://www.du.edu/tssgroup/womenshealth/>. In addition, flyers and other materials to assist in getting the word out are available at <http://www.du.edu/tssgroup/womenshealth/agencyinfo>. Please let us know if we can drop flyers off to you for display at your agency.

Getting the Word Out: Partnering to Access Legal Services Project. In collaboration with the Rocky Mountain Victim Law Center and several Denver-area agencies, we are entering the third and final phase of the legal needs assessment of the Partnering to Access Legal Services (PALS) Project. In this final phase, we invite adults (age 18 or older) who experienced a crime, or know someone well (such as a loved one) who experienced a crime, or work with crime victims to complete a survey that will take about 30 minutes. The results of this study will inform the development of programs to address gaps in legal services for crime victims in Denver and, eventually, throughout Colorado. You can read more about the project at <http://www.du.edu/tssgroup/pals>. Please let us know if we can drop flyers off to you for display at your agency or hard copies of survey packets for distribution at your agency.

On behalf of the TSS Group, we wish you a happy and healthy holiday season. We look forward to working with you in 2014!

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Healthy Adolescent Relationship Project (HARP): Main Findings

Anne DePrince and Ann Chu

WHAT WAS HARP AGAIN?

HARP tested two 12-week programs designed to help adolescent girls (ages 12–19) who came to the attention of the child welfare system learn about healthy relationships. [Program 1 \(Social Learning/Feminist Theory\)](#) taught teens about: power in relationship violence; skills to build healthy relationships; and social influences on violence (such as media messages). [Program 2 \(Risk Detection/Executive Function\)](#) taught teens about: safety in relationships, including how to recognize and respond to internal (e.g., one's own emotions) and external (e.g., other people's emotions, behaviors) safety signals; and attention regulation.

WHO PARTICIPATED?

We initially interviewed 180 adolescent girls, who ranged in age from 12 to 19 (average age = 15.85). Of the 151 teens who told us their race/ethnicity, 36% (n=54) identified as White/Caucasian, 36% (n=54) as Black/African-American, 3% (n=4) as Asian/Asian-American, 7% (n=11) as American Indian/Native Alaskan/Native American, 18% (n=28) as 'Other', and 67 (37%) as Hispanic/ Latina. The majority of teens (n=139; 77%) identified as "Heterosexual/ Straight".

After the first interview, 67 teens were randomly assigned to the Risk Detection/Executive Function program and 67 to the Social Learning/Feminist program. Teens who participated in the programs attended an average of nearly 70% of sessions. Another 42 teens did the interviews, but did not participate in either healthy relationship program (for example, because their schedules did not allow or they chose not to do so). We ran each of the two healthy relationships programs 12 times. After each round of healthy relationship programs ended, we interviewed teens 3 more times: immediately after and then 2- and 6-months later.

WHAT DID WE FIND?

Teens who participated in the Risk Detection/Executive Function group were nearly *5 times* more likely to *not* report sexual revictimization over the course of the study period compared to teens who did not participate in either group but completed interviews. A statistical trend also suggested that teens who participated in the Social Learning/Feminist Theory group were *2.5 times* more likely to *not* report sexual revictimization relative to the teens who did not participate in either group but completed interviews.

For physical revictimization, the odds of *not* being physically revictimized were *3 times* greater in the Social Learning/Feminist Theory group and *2 times* greater in the Risk Detection/Executive Function group compared to the group of teens who did not participate in either group but completed interviews.

While the primary goal of the current study was to look at revictimization, we also examined teens' ratings of physical, emotion, and sexual conflict tactics in dating relationships using a well-validated, continuous measure of aggression. Participants reported on their partners' as well as their own aggression at each interview. Across time, all teens (whether or not they participated in a healthy relationship program) reported significant decreases in physical and emotional/psychological aggressive conflict tactics.

We also asked teens to tell us what it was like to be part of the research interviews, which asked about their experiences of abuse and violence. Using a well-established measure (called the Response to Research Participation Questionnaire),

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[HTTP://WWW.DU.EDU/TSSGROUP](http://www.du.edu/tssgroup)



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adolescents reported that the benefits (for example, feeling respected, learning about oneself) of being part of these interviews far outweighed the costs (for example, feeling negative emotions, thinking about upsetting things).

WHAT DOES ALL THIS MEAN?

We tested two approaches to decreasing revictimization with adolescent girls from the child welfare system. Both approaches were linked with lower likelihood of reporting revictimization over time relative to teens who did not participate in the programs. Given the challenges that many teens faced in their daily lives (such as changes in school and care placements, teen parenthood), their participation in an average of 70% of sessions was quite impressive. Further, these programs were able to reach adolescents outside of traditional school settings, showing that youth can be engaged in alternative settings particularly when they are not consistently attending traditional schools. In addition, we were able to stay in touch with teens across four interviews, with 83% of teens completing the Time 4 interview. When we asked teens about being in the interviews, they reported significantly greater benefits of participating in these trauma-focused interviews than costs. As healthcare providers, counselors, and caseworkers increasingly need to screen for and address trauma/violence as part of providing effective mental and physical healthcare, this finding provides important information about assessing violence exposure as a routine part of practice.

THANK YOU!!

On behalf of our entire team, thank you for all you did to make this project successful. We look forward to continuing to work with you on other projects. We leave you below with some notes from teens in one of the HARP groups.

**So, after all these classes...
here's OUR advice to other teens:**

Get help when you need it – especially from friends and family.

Pay attention to warning signs in:

- **Other people** (like body language, facial expressions)
- **Yourself** (like your intuition or instincts)
- **The environment** (am I some place that isn't safe?)

**NOTICE! PAY ATTENTION!
STAY-OFF AUTOPILOT!**

Respect yourself!
Know your rights as a woman!
You have the right to stick up for yourself!
You are worth it!



ACKNOWLEDGE YOUR EMOTIONS! WATCH YOUR OWN SIGNALS!

Use your coping skills!

Know your boundaries – so you can know when they're being crossed!

Brainstorm **LOTS OF OPTIONS** when you notice danger clues!!

TAKE TIME AND SPACE TO SOLVE PROBLEMS

Abuse is never OK.
Don't put up with it.
Leave a dangerous situation when you need to.

PARTICIPATE AND PRACTICE! TAKE IT TO THE REAL WORLD!



Upcoming Project: Exposure to Trauma, Posttraumatic Symptoms, and Exercise

Jane Sundermann, MA, 5th Year Graduate Student

Physical exercise: A method for promoting mental health. Participating in regular physical exercise habits (e.g., biking, running, yoga) has well-known benefits for physical health, such as increasing energy and mobility, building stronger bones, and reducing risk for chronic diseases like cardiovascular disease and Type II Diabetes. In addition to the *physical* health benefits of exercise, regular participation in exercise also appears to have numerous *mental* health benefits. A growing number of studies link increased engagement in exercise (e.g., frequency, duration, intensity of exercise) to reductions in negative mental health outcomes like anxiety and depression (e.g., Alexandratos, Barnett, & Thomas, 2012; Eyre & Baune, 2012; Penedo & Dahn, 2005; Stathopoulou, Powers, Berry, Smits, & Otto, 2006). These findings suggest that clinicians in the mental health field (e.g., counselors, psychologists) may need to increasingly consider (including assessing and targeting) clients' exercise habits when planning and implementing mental health treatment.

Identifying risk factors for poor (or low) exercise habits may be particularly important among individuals who are already at high risk for developing mental health difficulties. One such high-risk group is survivors of trauma. Exposure to trauma increases risk for a host of negative mental health outcomes, including anxiety, depression, and symptoms of Posttraumatic Stress Disorder (PTSD). Figuring out what might stand in the way of (or alternatively promote) regular exercise habits among trauma survivors may provide important avenues for alleviating mental health difficulties among this population. Further, how individuals with posttraumatic distress and histories of trauma may perceive and react to exercise-related interventions is a question in need of empirical investigation.

Preliminary empirical evidence: The relationship between trauma and exercise. Very little is known about the potential impact that traumatic experiences have on individuals' exercise habits and behaviors. Studies have demonstrated that exercise participation levels are generally low (i.e. infrequent, less intense) among trauma-exposed populations (e.g., Buckley et al., 2004). However, such studies often lack appropriate, matched comparison groups of individuals not exposed to trauma. Thus, researchers have been unable to test hypotheses about the role of trauma in exercise habits. Only one study (Lang et al., 2003) – to the best of our current knowledge – has empirically investigated relationships between exposure to trauma and exercise habits. Based on women's self-reports, Lang et al. (2003) found that a history of sexual assault was associated with less vigorous exercise among women. However, the study design had significant limitations (e.g., cross-sectional, limited self-report measures), which prohibited a more in-depth, empirical investigation of the reasons for the observed association. In addition, because the study only assessed sexual trauma, whether other types of trauma would put individuals at risk for physical inactivity or poor exercise habits remains an empirical question to be addressed.

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An upcoming TSS Group project: We suspect that there are a number of mental health difficulties experienced by survivors of trauma that may affect their motivation to exercise, their affective responses to exercise, perceived costs and benefits of exercise, and actual engagement in exercise behaviors. We are extremely enthusiastic to pursue those possibilities within an upcoming research project. The project will test hypotheses about the specific ways in which exposure to trauma may affect exercise habits and motivation to participate in exercise. These hypotheses will involve testing the role of PTSD symptoms within the relationships between trauma and exercise, but also testing other conditions under which and mechanisms through which relationships between trauma and exercise occur. We know that survivors of trauma often experience significant changes in behavior (e.g., increases in substance use, social withdrawal), cognitions (e.g., intrusive and trauma-related thoughts), affect (e.g., depressed mood, hyper-arousal), and physiology (e.g., dysregulated stress response hormones), and we hypothesize that some of these changes may affect exercise behaviors, and in turn, physical and mental health.

We are excited that the information obtained through the upcoming project will fill gaps in knowledge about the impact of traumatic experiences and trauma-related symptoms on physical exercise habits. We also hope that knowledge generated through the study has relatively direct implications on practice – potentially offering enhanced understanding of the unique barriers that trauma may present to survivors in terms of engagement in health behaviors like exercise. We look forward to keeping you in touch about the upcoming project, and as usual – keep in touch!

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Child Symptoms: Examining Mothers' Betrayal Trauma Histories and Parenting Attitudes

Becca Babcock, MA, 4th Year Graduate Student

The development of psychopathology among children is a considerable public health concern. Identifying factors that may contribute to the development of childhood disorders, both internalizing disorders (e.g. depression, anxiety), and externalizing disorders (e.g. oppositional defiance, conduct disorder) is essential to informing early intervention strategies. Previous research has found that children of mothers with a history of childhood abuse are at an increased risk for developing early psychopathology; this occurrence has been referred to as the "intergenerational transmission of trauma" or trauma-related distress (Bosquet Enlow, et al., 2009; Dekel, & Goldblatt, 2008; Hulette, Kaehler, & Freyd, 2011; VanDeMark, et al., 2005). Furthermore, parenting factors, like mother-child relationship quality, have also been linked to symptom development during childhood (Easterbrooks, Bureau, & Lyons-Ruth, 2012; Costa, et al. 2006; Kim & Cicchetti, 2004; Reitman, et al., 2002).

In 2006, Chu and DePrince addressed research gaps by investigating whether maternal history of abuse that involved an interpersonal betrayal (i.e. abuse perpetrated by a closer other like a parent; Freyd, 1994) and children's reports of mothers' inconsistent parenting would predict higher levels of dissociation among children. Among a sample of 72 mother-child dyads (with children between the ages 7 and 12) in the Denver Metropolitan area, maternal experiences of betrayal trauma during their own childhoods predicted higher levels of dissociation among their children, although child reports of mother's inconsistent parenting was not significantly linked with child dissociation in the study. Another study has since replicated the results found by Chu and DePrince (2006), in 2011 Hulette and colleagues found that among a sample of 67 mother-child dyads, mother's betrayal trauma histories predicted higher levels of dissociation in both children and the mothers themselves (Hulette, Kaehler, & Freyd, 2011).

Recently, analyses were conducted with data from the same sample of mothers and children to explore whether: a) mother's experiences of betrayal trauma predict a broader range of symptoms beyond dissociation in their children, like internalizing and externalizing symptoms; b) whether other parenting factors, such as mother's attitudes towards parenting or their children, would predict children's internalizing and externalizing symptoms in addition to maternal betrayal trauma. To assess these attitudes mothers reported about the following topics: their satisfaction with parenting, support they receive as a parent, involvement, communication, and setting limits with their child, promoting their child's autonomy and gender roles.

Consistent with the findings from Chu & DePrince (2006), mother's experiences of betrayal trauma during their own childhood significantly predicted higher levels of *both* internalizing and externalizing symptoms in their children. In addition to mothers' betrayal trauma histories, specific parenting attitudes were also found to predict symptoms. Mothers who reported receiving lower levels of parenting support, but also higher levels of satisfaction with parenting had children with significantly higher levels of internalizing symptoms than mothers who did not report such attitudes. The picture was different for externalizing symptoms, with more negative maternal attitudes towards limit setting significantly linked

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to higher levels of externalizing disorders in their children. Analyses were also conducted to see whether mothers' reports of having dysfunctional interactions with their children could explain the associations between these specific parenting attitudes and symptoms in their children. Though higher levels of dysfunctional parent-child interactions did not, in and of itself, explain these associations, higher levels of dysfunctional mother-child interactions were also linked to higher levels of internalizing, but not externalizing, symptoms in this sample of children.

The results from the current study indicate that mothers' betrayal trauma histories, their attitudes towards parenting and their child as well as their perceptions of dysfunctional interactions with their child may increase children's risk for developing symptoms that impact both their mood and behavior at a young age. Although further research is necessary to confirm and elaborate the impact such factors have on mothers' and children's relationships and social-emotional well-being; we do hope this research can provide some evidence that may assist in guiding practitioners who provide interventions to high-risk mothers and their children.

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Sure, we know lots of facts and figures about unwanted sexual experiences.



But, facts and figures don't tell the whole story.

Each woman's story is unique.

Learn about the Women's Health Project.

- ✓ Have you had an unwanted sexual experience in the last year?
- ✓ Did you tell someone (such as a counselor, advocate, police officer, health provider) about that experience?
- ✓ Are you 18 years of age or older?

Women who answer yes to these questions are invited to participate in the Women's Health Project.

WHAT DOES THE PROJECT INVOLVE?

- 4 interviews over 9 months with a female interviewer.
- The first interview takes 3 hours; the others each take 2 hours.
- Everything in the interview is voluntary. You do not have to answer any questions you do not want to answer.
- We are trying to learn:
 - ... what can people say and do to help after an unwanted sexual experience?
 - ... what is it like to talk to counselors, health providers, advocates, lawyers, or the police?
 - ... what makes it easier or harder to cope?
 - ... what is it like to try to find services that can help?

WILL MY COUNSELOR OR THE POLICE KNOW THAT I AM IN THE STUDY?

No. We will not tell anyone you are in the study. We keep everything you tell us about your experiences private.

WILL I BE PAID FOR MY TIME?

Yes! To thank you for your time, you can receive up to \$230 total, as follows: \$50 for the first interview, \$55 for the second interview, \$60 for the third interview, \$65 for the fourth interview.

WHAT ABOUT GETTING TO THE INTERVIEW?

We can help with cab fare, bus tokens, or \$10 cash for transportation costs. You tell us which you prefer.

CONTACTING US

For more information, please contact us:

Private email: healthstudy@du.edu Private phone: 303.871.4103 Website: www.du.edu/tssgroup/womenshealth

Agency information for the project is available at <http://www.du.edu/tssgroup/womenshealth/agencyinfo>