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Women trauma survivors' experiences of returning to work: an exploratory study

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WOMEN TRAUMA SURVIVORS' EXPERIENCES OF RETURNING TO WORK:
AN EXPLORATORY STUDY

A dissertation presented by

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ABSTRACT

This exploratory study examined the experiences of fifteen women trauma survivors who were returning to work. All participants had histories of interpersonal violence and were receiving mental health counseling for post-traumatic stress disorder and vocational services from a state vocational rehabilitation program. Using a feminist qualitative research method, the participants were interviewed and the data analyzed for common and emergent themes. The findings underscore significant factors that include health concerns, treatment, family and community support, and accessing resources such as affordable housing, health care, and disability benefits. Implications for mental health and vocational rehabilitation counselors include increased awareness of the challenges that influence career decision making, job readiness, and successful returning to work and a call to eliminate institutional barriers.

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Always forward.

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CHAPTER ONE

INTRODUCTION

This study brings to light the lived experiences of women trauma survivors who are returning to work. Interpersonal violence impacts women in multiple aspects of their lives. The psychological, emotional, and social effects of interpersonal violence are well-documented (Breire, 1992; Courtois, 2004; Herman, 1997; Kluft, 1990; McLean & Gallop, 2003; Murray, 1993; van der Kolk et al., 2005). However, few studies have focused specifically on how interpersonal violence affects women's working lives.

Women who have histories of interpersonal violence and experience severe symptoms associated with posttraumatic stress disorder (PTSD) and complex PTSD may have difficulty securing and maintaining paid employment. Posttraumatic responses to interpersonal violence can produce incapacitating feelings of "intense fear, helplessness, loss of control, and threat of annihilation" (Herman, 1997, p. 33). Mueser et al. (2004) stated, "People with PTSD were less likely to seek work, less likely to be hired, and/or more likely to lose their jobs" (p. 914). Few studies on PTSD and complex PTSD, however, focus on women trauma survivors' experiences of returning to work.

The Prevalence of Violence among Women

Women are more likely to be victims of interpersonal violence than their male counterparts. The Centers for Disease Control and Prevention found that "intimate partner violence accounted for 20% of non-fatal violence against

women in 2001 and 3% against men” (The Centers for Disease Control and Prevention, 2006, Occurrence section, p. 2). Most violence experienced by women is perpetrated by men (Tjaden & Thoennes, 1998). According to the Family Violence Prevention Fund (2007), “Nearly 25% of American women report being raped and/or physically assaulted by a current or former spouse, cohabitating partner, or date at some time in their lifetime,” and up to “three million women are physically abused by their husband or boyfriend per year” (Family Violence Prevention Fund, 2007, Prevalence of Domestic Violence, p. 1). Mays (2006), a feminist disability writer, argued that interpersonal violence against women “needs to be understood in terms of the relationship to gendered power relations and the historical, social, and material conditions that perpetuate and reinforce violence” (p. 151). Mainstream literature on violence against women may mask entrenched power structures in society that are historically linked to gender inequality.

The Importance of Work

The importance and benefits of work for people with disabilities are well documented and have implications for women trauma survivors with histories of interpersonal violence. The research by Laudet, Magura, Vogel, and Knight (2002) on dually diagnosed individuals (that is, individuals diagnosed with both substance use and mental health disorders) and work suggested that paid employment provides daily structure, reduces isolation, and increases social connection. They further stated that “employment has both economic and non-economic benefits for recovering

individuals and contributes to higher-level functioning” (Laudet et al., 2002, p. 147).

Judith Herman, psychiatrist and author of *Trauma & Recovery* (1997), stressed the importance of social connection and reconnection for trauma survivors. She stated that “reconnection serves as [a] core experience of recovery” and signifies an advanced stage of trauma recovery (p. 197). Work can be a vehicle for reconnecting individuals to their communities.

Existing Literature on Women, Work, and PTSD

The few existing studies examining work issues focus on college-age and older battered women who live in shelters. For example, Albaugh and Nauta (2005) studied the relationship between career decision making, career barriers, and intimate partner abuse among college age women. This empirical study found that college-age women who experienced sexual coercion through dating relationships or intimate partners experienced negative effects on their career self-efficacy. Wettersten et al. (2004) focused in their qualitative study on the vocational needs of battered women living in shelters. Wettersten et al. found that external factors (for example, the presence of children or lack of resources) pose significant obstacles to the return to work for women survivors who live in shelters. Wettersten et al. argued that a need exists for more research on the vocational needs of women trauma survivors, and that “domestic violence and vocational concerns are largely unaddressed by the academic community” (p. 447).

A considerable amount of literature exists on women with various mental health issues and the barriers and benefits they face regarding employment (Lucas &

Ancis, 2000; Warr & Parry, 1982; Washington & Moxley, 2003). However, significantly less research exists on the relationship between PTSD and employment. In one study, Mueser et al. (2004) focused on outcomes of individuals who experienced comorbid disorders of severe mental illness (SMI) and posttraumatic stress. Their study found that people with SMI and PTSD were less likely to be employed than those without PTSD. The results of this study are not surprising and underscore the serious impact PTSD has on work functioning.

The Relative Areas of Expertise of Mental Health Counseling, Vocational Rehabilitation Counseling and the Importance of Work to Women Trauma Survivors

Mental health counselors are trained to provide counseling to individuals, couples, families, adolescents, and children. Mental health counselors provide services that may include psychotherapy, psychological assessment, diagnosis, treatment planning, and crisis management.

Mental health clinicians who treat individuals with PTSD are aware that an increase in PTSD symptoms can be detrimental to daily functioning. What many mental health professionals miss is that work remains elusive for those who have more severe forms of PTSD and psychiatric disabilities. Without effective treatment for severe PTSD symptoms, individuals may have difficulty obtaining and/or retaining employment (Rutman, 1994). In addition, the return to work is made more difficult by the currently less forgiving and more competitive job market, which places increasing demands on workers (Labor Research Association Online, 1999, “Lower Wage Jobs Will Fill the Economy”). Today, more jobs in the service

industries offer fewer benefits (for example, health care, sick leave, childcare, and vacation time) and demand longer hours for less pay (Gavin, 2006; Labor Research Association Online, 1999).

Some mental health clinicians may possess little to no knowledge of today's job market and world of work. This lack of data may be related to a lack of training in vocational counseling and career development. The training, licensure, and credentialing processes for psychiatrists, social workers, and clinical psychologists do not require competencies in vocational psychology or career development (American Board of Psychiatry and Neurology, 2007; Massachusetts Board of Registration of Psychologists, 2007; National Association of Social Workers, 2007). The yardstick for recovery and healing within a clinical setting does not necessarily correspond to the ability to make good career decisions or maintain employment. In their desire to help patients return to work or pursue a career, mental health clinicians may inadvertently support unrealistic vocational goals. Patients may have little knowledge of the demands of competitive employment or postsecondary training programs, which decreases their ability to make informed decisions regarding their vocational goals (Rutman, 1994). Given the increased competitiveness and complexity of the current job market, mental health clinicians may benefit from increased knowledge and awareness of work-related issues in assisting patients toward their work goals.

Vocational rehabilitation serves as an important connection to community and facilitates the return to work for individuals with PTSD. Vocational rehabilitation counselors assist individuals with disabilities in obtaining and maintaining employment. Vocational rehabilitation counselors help assess and identify clients'

strengths, limitations, work interests, and aptitudes to develop realistic job goals.

While vocational rehabilitation counselors' area of expertise is in helping prepare individuals for entry into the world of work, these counselors may not be able to recognize or address the mental health issues associated with complex PTSD.

Fogarty and Beck's (2004) pivotal article reviewing the literature on work adjustment and PTSD outlined important work adjustment issues unique to individuals who struggle with PTSD symptoms. The authors suggested that rehabilitation counselors who assist individuals with the return to work may be unaware of the distinct sensitivities and challenges experienced by people with PTSD. For example, rehabilitation counselors may be unaware that during "periods of high stress" individuals with PTSD may experience an exacerbation of or increase in symptoms that diminish work functioning (Fogarty & Beck, 2004, p. 76). Symptoms may include re-experiencing the traumatic event(s), avoiding stimuli related to the traumatic event(s), and increased emotional arousal (American Psychiatric Association, 1994). Fogarty and Beck emphasized the importance for those who assist clients with PTSD of being cognizant of issues and challenges related to the return to work.

This study intends to speak to the need for better communication and knowledge sharing between mental health and vocational rehabilitation professionals who serve women who are challenged by symptoms closely associated with PTSD.

The Project

This project was exploratory in nature and used a feminist qualitative methodology to examine women trauma survivors' experiences. The purpose of this study was to examine women trauma survivor's experiences within the context of work. Semistructured interviews, which were conversational and relational in nature and were consistent with a feminist methodology, were employed to gather data. A qualitative design using semistructured interviews directly accesses women trauma survivors' experiences, develops recurrent emergent and themes, and lays the groundwork for future research (Creswell, 2003). Women's own words hold important insights for their vocational rehabilitation and trauma recovery. They also hold critical knowledge for the fields of mental health and vocational rehabilitation counseling.

Central to this study was the feminist principle that women are experts on their own experience. Women's experiences hold important and critical insights for other women trauma survivors and the professionals who work with them. It was my intent that participants in this study (1) share their experiences in returning to work so as to educate and inform professionals in the field, (2) reclaim their power by telling their stories, and (3) move forward in their own vocational rehabilitation.

This study aimed to explore the following questions:

1. How do women trauma survivors perceive and report their work histories?
2. What are the mental health counseling experiences of women trauma survivors who are returning to work?
3. What are the vocational rehabilitation counseling experiences of women trauma survivors who are returning to work?

4. What factors do women trauma survivors perceive as facilitators and as barriers to employment?

This inquiry will make central the experiences of women trauma survivors who receive vocational rehabilitation services. It intends to shed light on the sensitivities and challenges unique to a population often ignored by the academic community. The existing literature suggests that the return to work is difficult for women who have histories of chronic abuse. For them, the road to employment is marked by a series of trials and failures. However, the literature points to the notion that work provides opportunities for women to build self-esteem and create new identities other than that of “trauma survivor” or “victim.” Work helps women develop self-images that embody competence and potential. Work also connects women to the community at large and increases their financial security and independence. How best to facilitate this move toward employment for women trauma survivors was the central concern of this study.

CHAPTER TWO

LITERATURE REVIEW

Chapter two will provide a critical overview of the literature covering women trauma survivors, PTSD, and employment. This chapter's four sections will review relevant research that covers: (1) the negative effects of interpersonal violence, (2) the importance of work, (3) facilitators and barriers to employment, and (4) career decision making and vocational counseling. Each section contains related subtopics.

The Negative Effects of Interpersonal Violence on Women

Definition of Interpersonal Violence

The Centers for Disease Control and Prevention outline four types of intimate partner violence. They are: (1) physical violence, (2) sexual violence, (3) threats of physical or sexual violence, and (4) psychological/emotional violence (CDC, 2006). These forms of violence also describe the possible categories of interpersonal violence. According to the World Health Report on Violence and Health (Krug et al., 2002), interpersonal violence comes in two forms. One form of interpersonal violence is family and intimate partner violence (Krug et al., 2002). This type of violence takes place in the home. Community violence is another form of interpersonal violence. Community violence is typically perpetrated by a stranger or acquaintance and takes place outside the home (Krug et al., 2002).

Pervasiveness of Interpersonal Violence for Women

According to the Centers for Disease Control and Prevention's National Center for Injury Prevention and Control, approximately 5.3 million incidents of interpersonal violence (IPV) "among U.S. women ages 18 and older" occurred in 2006 (CDC, facts sheet, 2006). In addition, the CDC found that "29% of women had experienced physical, sexual, or psychological IPV during their lifetime" (CDC, facts sheet, 2006). A survey commissioned by the Commonwealth Fund (1998) found that approximately "two in five women hav[e] experienced at least one type of abuse or violence in their lifetime" (Collins et al., 1999, p. 7). The Commonwealth Fund survey also found that low-income women are at increased risk of being victims of domestic violence irrespective of race and other demographic factors (Collins et al., 1999). The emotional and psychological impact of IPV can significantly limit functioning and have negative effects on women's health and employment (Arias, 2004; Brown et al., 2000; Chronister et al., 2004; Diehl & Prout, 2002; Hall, 2000; Hegadoren et al., 2006).

The Impact of Interpersonal Violence on Women with Disabilities

Women with physical disabilities are particularly vulnerable to high rates of abuse and may experience reoccurring abuse and maltreatment from caregivers and intimate partners. Irwin's (2000) report on interpersonal violence and women with disabilities found that a significant percentage of women with disabilities experience some form of caregiver or intimate partner abuse. Hassouneh-Phillips and McNeff's (2005) study showed that women with physical disabilities are "often victimized by multiple perpetrators" and are less able to break the cycle of violence than women

without physical disabilities (p. 229). For women with disabilities, IPV creates additional barriers to employment.

Psychological Effects of Interpersonal Violence

The *Diagnostic and Statistical Manual of Mental Disorders* outlines diagnostic criteria and symptoms associated with PTSD and other mental disorders. According to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (APA, 1994) (DSM IV), the diagnostic criteria for PTSD are: “(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; and (2) the person’s response involved fear, helplessness, or horror” (pp. 427-28). The diagnosis of PTSD is also determined by a subset of the symptoms. Symptoms include (1) reoccurring distressing experiences of “images, thoughts, or perceptions” and/or dreams of the traumatic event(s); (2) reliving the trauma event(s) by way of illusions, hallucinations, and dissociative flashback episodes; (3) psychological distress/disturbance and physical reactivity to internal and external triggers that symbolize or resemble the event(s); (4) inability to recall events related to trauma and avoidance of thoughts, feelings, conversations, activities, places, or people that evoke memories of the trauma; (5) detachment and social isolation; (6) restricted range of affect; and (7) a sense of foreboding related to one’s future (p. 428). Other PTSD symptoms may include difficulty falling asleep, irritability, decreased concentration, and hypervigilance.

Herman (1997) found limitations in the DSM IV definition of PTSD and argued that this definition more closely represents a “prototype” of the survivor.

Typically, this particular “prototype” describes experiences and symptoms resulting from a specific traumatic incident (for example, combat) rather than “prolonged and repeated abuse” (p. 119). To cover the trauma responses of survivors who have histories of childhood abuse and neglect, Herman proposed an expanded diagnosis: complex posttraumatic stress disorder (CPTSD). Courtois (2004) described complex trauma as “a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts” (p. 412). She also asserted that the current PTSD diagnosis does not fully describe the experiences of “individuals exposed to trauma over a variety of time spans and developmental periods” (p. 413). Complex PTSD is also known as DESNOS or “disorders of extreme stress not otherwise specified” (Herman, 1992; van der Kolk et al., 2005).

Complex posttraumatic stress disorder expands upon the PTSD diagnosis and experience and provides a spectrum of trauma responses. A simple PTSD diagnosis does not include “depression, anxiety, self-hatred, dissociation, substance abuse, self-destructive behaviors, revictimization, problems with interpersonal and intimate relationships (including parenting), medical and somatic concerns, and despair” (Courtois, 2004, p. 413). PTSD and comorbidity of other disorders are common among trauma survivors who experience symptoms associated with PTSD.

Comorbidity can be understood as a co-occurrence of at least two psychological disorders (Orsillo et al., 2002). Mood and anxiety disorders commonly co-occur among trauma survivors who experience symptoms associated with PTSD (Orsillo et al., 2002).

The more severe and chronic forms of interpersonal violence such as childhood physical and sexual abuse are more likely to lead to psychiatric problems in adulthood (Briere, 1992; Herman, 1997; van der Kolk, 2005). Some psychiatric problems associated with childhood maltreatment and abuse include substance abuse, borderline and antisocial personality disorder, and eating, dissociative, affective, somatoform, and sexual disorders (van der Kolk; Herman; Briere). Van der Kolk et al. (2005), in his study on children and adults with histories of interpersonal violence whose trauma symptoms were not encapsulated by PTSD diagnostic criteria, found a strong relationship between prolonged interpersonal trauma and psychiatric problems experienced in adulthood. He found that battered women and rape victims experienced “long-term problems in areas of attention, self-regulation, and personality structure” (p. 390).

The psychological consequences of interpersonal violence depreciate the quality of life for women and affect women’s health and well-being, as well as posing significant challenges to the return to work for women trauma survivors. Identifying PTSD symptoms and assessing psychological functioning are critically important to the rehabilitation process and return to work for women survivors.

The Impact of Interpersonal Violence on Women’s Health

Hegadoren, Lasiuk, and Coupland (2006), in their paper *Health Effects of Interpersonal Violence among Women*, cited various studies showing the adverse effects of childhood physical and sexual abuse (CSA) on women’s health. What these studies revealed is a close association of CSA with health problems that include chronic pelvic pain, gastrointestinal disorders, low back pain, and chronic headache

(Hegadoren et al., 2006). In addition, Hegadoren et al. (2006) discussed the effects of interpersonal violence on the “human stress response system,” otherwise known as the “flight or flight response” (p. 165). Increased levels of cortisol can have negative effects on the autoimmune and cardiovascular systems and lead to a complex range of medical conditions that may include those affecting the cardiovascular, respiratory, musculoskeletal, and neurological systems (Hegadoren et al., 2006; Resnick, 1997). The CDC (2006) reports that women with histories of interpersonal violence face increased health risks because they are more likely to engage in unprotected sex, abuse substances (for example, alcohol and drugs), practice unhealthy eating habits, and/or follow extreme diet regimens that include fasting, vomiting, overeating, and/or abusing diet pills and laxatives. Many negative health behaviors are directly related to complex PTSD symptoms resulting from psychological trauma and a damaged sense of self or distorted self-image (Herman, 1997).

The Importance of Work for Women Trauma Survivors

Breaking the Cycle of Violence

Financial independence through employment can break the “cycle of violence” and keep women from returning to abusive relationships or repeating destructive patterns. Women ensnared in the cycle of violence can find themselves socially isolated and disconnected from their family, friends, and community. Chronister et al.’s (2004) extensive review of the literature on battered women emphasized the importance of paid employment in breaking the cycle of violence and identified important factors that facilitate the return to work.

Work and Reconnection to Community

Judith Herman's model of recovery stressed the importance of reconnection as one of the advanced and critical stages of recovery that indicates that "the survivor is ready to engage more actively in the world" (Herman, 1997, p. 197). Herman characterized this advanced state of recovery as one in which survivors can "recover lost aspirations" and "revisit old hopes and dreams" (Herman, 1997, p. 202). Recovery is a process of developing a new identity separate from the one marked by abuse and mistreatment. Ideally, women survivors late in their recovery feel more empowered and develop an identity that embodies a positive self-image. On the other hand, negative self-image evaluations keep women from taking risks and engaging in training and job opportunities. Women survivors' negative self-images often develop as a consequence of long-term abuse and exploitation by intimates and larger social and cultural structures and institutions. Recognizing and identifying the process of socialization rooted in gender stereotypes may ameliorate women survivors' negative self-concepts and self-images and be helpful in terms of recovery.

Few trauma recovery models identify work as one of the main facilitators of recovery. Rather, most recovery models identify emotional and psychological factors important to recovery. For example, the ecological model views trauma and recovery within a larger social context and makes central the relationship between the individual and the environment. Harvey (1996), in her paper "An Ecological View of Psychological Trauma and Trauma Recovery," described how trauma and recovery are influenced by complex interactions between survivors, traumatic events, and

community. The ecological model views trauma and recovery as being influenced by environmental variables that include social, political, cultural, and economic factors (Harvey). Although the ecological model may broadly consider how women's race, class, education, and/or sexual orientation affect the trajectory of trauma recovery, it does not make gender a focal point within the framework of trauma and recovery. This perspective is unlike feminist models, which make central the relationship between gender and trauma. The important dynamic between gender and trauma and the complexities it generates directly affect the recovery process and return to work. The influences of gender and trauma cannot be ignored, particularly within the context of women survivors' recovery and return to work, as this study will discuss throughout.

The Psychosocial Benefits of Work for Women

For women trauma survivors, the return to work is critical to the recovery process. Work engages the outside world and provides women with opportunities to learn, grow, and realize their achievements. Work builds women's self-esteem and self-confidence. Betz (1994), in her chapter "Basic Issues and Concepts in Career Counseling for Women," stressed the importance of paid employment to women's psychological functioning. Betz's conceptual framework integrated research and theory on women's career adjustment and covered "gender differences in job performance, success, satisfaction, motivation, discrimination, sexual harassment, and work-family interface" (p. 2). In her review of the literature and discussion on women's life satisfaction and success, she cited a longitudinal study by Sears and Barbie (1977) that followed a sample of intellectually gifted women into their sixties.

The Sears and Barbie study showed that women with high intellectual functioning who pursued careers and were employed reported higher levels of life satisfaction than women homemakers with high intellectual functioning who never held paid employment. Betz also found that unemployed women, regardless of their socioeconomic status in general, experienced more “psychological disturbances” (Betz, p. 3) than their employed counterparts.

Brown et al.’s (2000) study on battered women and career decision making found that battered women who were employed were better able to benefit from the career decision-making process (that is, the initiation and exploration of vocational interests, training, and job opportunities) for long-term vocational planning than women who were unemployed. The study interviewed and assessed 71 women participants who were living in six domestic violence shelters. The researchers administered a range of instruments to assess and measure career decision making and career self-efficacy, internal/external loci of control, and self-esteem. The instruments used were the Career Decision-Making Self-Efficacy Scale-Short Form (CDMSE); the Career Barriers Inventory-Revised; the Rotter Internal-External Control Scale; the Coopersmith Self-Esteem Inventory, Adult Form; the Work Role Attitude scale; and a demographic questionnaire.

The CDMSE measures “self-efficacy for career decision-making tasks”; “higher scores reflect greater confidence in career decision-making tasks” (Brown et al., 2000, p. 256). The results of the CDMSE showed that battered women who were employed scored higher in the areas of self-esteem and self-efficacy than battered women who were unemployed. Interestingly, when battered women’s scores on the

CDMSE were compared to a sample of college females, battered women scored significantly lower.

These results support the idea that interpersonal violence has a devastating effect on battered women's self-esteem and confidence, and that women's self-esteem and confidence are essential to good career decision making. This study also showed that "battered women who report high self-esteem may be more likely to possess the confidence needed to implement vocational planning" (Brown et al., 2000, p. 263).

Gianakos (1999) concluded from her study on career counseling for battered women that the career decision-making process for women can be significantly compromised by "low self-esteem and poor self-concept" (p. 11). This study interviewed 20 women participants aged 25 to 46 years from working class and lower socio-economic backgrounds. Of the participants, 15 were living with their abusers. Six women in the study were employed, while the majority remained unemployed. The study found that women with low self-esteem and poor self-concept experienced difficulty initiating and following through with career exploration and job search activities. Interestingly, the majority of women in Gianakos' study were unemployed and had "low self-esteem and poor self-concept," which seems to suggest that a strong relationship exists between employment and women's self-esteem. More specifically, these findings support the idea that work has a positive effect on women's self-esteem.

Betz (1994), Brown et al. (2000), and Gianakos (1999) stressed the importance of work for women and the positive effects that work has on women's self-esteem and confidence. For women trauma survivors, work is not only important

for self-esteem and self-concept but also with regard to diminishing the social isolation many women survivors experience as a result of a history of abuse.

Barriers to Employment

Effects of Interpersonal Violence on Work

As mentioned earlier in this chapter, psychological problems associated with childhood sexual abuse (CSA) and physical abuse can negatively impact the return to work for women. Psychological functioning is critical to career development and work adjustment. Childhood abuse and maltreatment can also affect women's career development and work adjustment (Gianakos, 1999; McWhirter & Chronister, 2003). However, few studies have been performed on the relationship between childhood abuse and maltreatment and work functioning in adults.

Studies also show that child sexual abuse survivors have difficulty in areas of emotional and self-regulation. Diehl and Prout's (2002) article on the effects of PTSD and child abuse on self-efficacy development argued that "sexually abused children often develop into adults who use ineffective emotional-regulation strategies" (p. 263). The authors suggested that self-regulation and emotional modulation strategies are important for women survivors in order to manage stress and deal with interpersonal conflict (Diehl & Prout). According to Diehl and Prout, emotional regulation is "the ability to control one's subjective experience of emotion" (p. 263). Self-regulation is the "ability to direct one's actions, thoughts, and feelings in an adaptive manner" (Diehl & Prout, p. 263). Coping with stress and interpersonal conflict are critical to sustaining employment. Emotion-focused strategies help

individuals with PTSD cope with situations in which they believe they have little to no control. This article did not, however, specifically address the effects of emotional dysregulation on trauma survivors' return to work (Diehl & Prout).

Diehl and Prout (2002) suggested that women who have histories of childhood abuse report "higher levels of self-blame, self-denigration, and low self-efficacy" (p. 263). The authors also proposed that women survivors are more likely to "blame themselves for negative events" and attribute achievements to "external factors" rather than to their own efforts and aptitudes (p. 263). Sexually abused children are sensitive to "heightened self-blame" and develop cognitive distortions and negative self-images because they are not developmentally mature enough to "make sense out of abusive events" (Diehl & Prout, p. 263). Caretakers, intimate partners, and communities influence women survivors' negative self-images and perceptions (Arias, 2004; Briere, 1992; Hall, 2000; Herman, 1997; Widom & Colman, 2004).

Hall's (2000) article examined women survivors' experiences of the barriers to education and work. Her analysis of the interviews with women survivors found that the psychological consequences of early abuse narrowed "life's options" for many and that the return to work requires motivation, skill, aptitude and resources for planning and making good decisions, and the ability to take risks (Hall, p. 446). Hall concluded that many of the women who were interviewed did not have the social support, knowledge, emotional resources, and physical health to initiate and pursue education and training.

Effects of Interpersonal Violence on Financial Independence and Security

Hyman (2000) posited that regardless of economic status, childhood sexual abuse limits women's ability to financially support themselves and their family. Hyman's research on lesbian women with histories of childhood sexual abuse showed the negative consequences of childhood sexual abuse on health, education, and economic status. The majority of women were college-educated and working. Even with postsecondary educations and careers, the women in this study reported "adverse economic consequences of the experience of child[hood] sexual abuse" (Hyman, p. 208). Of the women surveyed, "60% earned less than \$20,000 per year and 28% earned less than \$10,000 per year" (Hyman, p. 203). Three factors were identified as affecting women's earnings: (1) knowledge of career and occupational information, (2) ability to initiate career plans and take risks; and (3) self-confidence to initiate career plans.

Hyman's study revealed that the long-term effects of CSA negatively impact women's abilities to initiate and participate in vocational training and/or organize a job search. Hall (2002) and Hyman (2000) found that social isolation and low self-confidence negatively affect new learning and risk-taking behavior. Taking risks is critical to the return to work. Studies show that low risk-taking behavior may prevent survivors from exploring job opportunities and/or participating in vocational or college training (Hall; Hyman). However, serious pitfalls can accompany taking risks without good career decision making. Good decision making requires having the relevant information and knowledge to make informed choices. The stakes are often

higher for poor women when taking risks because they frequently lack adequate financial resources and support.

Multiple Barriers to the Return to Work

Hall's (2000) study on urban, low-income women abuse survivors who were in "recovery from substance abuse" outlined significant barriers to increasing job readiness (p. 449). Hall found that the women who were interviewed lacked sufficient money, time, and childcare management skills to pursue employment successfully. The study included interviews with 20 women trauma survivors. Most of the participants were women of color. Some of the interviewees had psychological disorders, learning disabilities, struggled with illiteracy or sobriety, or were experiencing health problems. Many of the women in Hall's study lacked resources and support from significant others. Hall concluded from her examination of the interviews that "treatment is not a precursor to becoming work-ready, and work is not an optional rehabilitative activity to supplement mental health care" (p. 465). Hall also alluded to an important point, namely that successful vocational rehabilitation for low-income women trauma survivors requires a collaboration of community services. The collaboration of services and community supports includes a combination of mental health treatment and vocational rehabilitation (Hall). This important issue has not been satisfactorily addressed by the field of mental health or vocational rehabilitation.

Chronister, Wettersten, and Brown (2004), Hall (2000), and Gianakos (2000) cited myriad barriers to career decision making and employment for women survivors. These researchers found that the women in their studies rarely considered

exploring nontraditional and higher-paying occupations and linked this phenomenon to lack of support and fear of disapproval from significant others. Other career barriers cited in these studies included work adjustment issues, limited networking opportunities, and limited access to community resources. Fatigue, time management difficulties, and role overload were the most reported work adjustment issues among women in Gianakos's study on the impact of abuse on career decision-making behaviors (Gianakos, 1999).

Effects of Discrimination in the Workplace

Brown et al.'s (2000) study on battered urban, low-income women in shelters found that many women believed that racial discrimination and lack of vocational preparation and training were key barriers to meaningful careers. Discrimination in the workplace affects hiring and promotional opportunities for women trauma survivors returning to employment. Employers may hold stereotypes around hiring or promoting individuals with major mental illnesses, including PTSD. Randolph (2004) cited literature showing that employers view employees with physical disabilities more favorably than those with mental or emotional disabilities. Studies also show that women with mental illness with significant employment gaps are less likely to be employed than men with similar mental health histories (Randolph, 2005; Razzano & Cook, 1994). She also found that women with disabilities "have lower employment status and income than men or non-minorities with disabilities" (Randolph, 2004, p. 260). For example, Randolph (2004) found that women with disabilities earned 65% of the salary of their male counterparts, even in cases where the women were better educated than the men.

Other Factors Affecting the Return to Work

Regional and demographic factors such as culture, socioeconomic status, marital status, employment status, education, transportation, and access to community resources create barriers for career and employment opportunities for women survivors (Brown et al., 2000; Chronister et al., 2004; Wettersten et al., 2004). Women survivors' social and economic status, ethnicity, marital status, sexual orientation, and living circumstances vary, as is the case in the general population. Career training and employment opportunities also differ depending on region. Comprehensive needs assessment by helping professionals that considers variations in demographics and career and employment opportunities is critically important to women trauma survivors' successful return to work (Allen et al., 2004; Brown et al., 2000; Gianakos, 1999).

Albaugh and Nauta (2005), Wettersten et al. (2004), Brown et al. (2000), Hyman (2000), and Gianakos (1999) studied a range of populations of women survivors who were returning to work. Some women in these studies were working, while others were participating in vocational and college training programs (Albaugh & Nauta, 2005; Hyman, 2000). The women participants in these individual studies had divergent experiences and circumstances related to their trauma(s), recoveries, and employment. For example, in Brown et al.'s study, the women participants were low-income, lived in domestic violence shelters, and came from diverse racial and cultural backgrounds. The women in this study had minimal education and were mostly unemployed. They also reported that some of the greatest barriers to employment were racial discrimination and inadequate preparation. When asked

about their needs related to career development, education and training, and basic needs (for example, housing, daycare, and transportation) they reported wanting career development and career exploration to evaluate their aptitudes, abilities, and vocational interests to match with suitable careers. They also reported wanting “housing, transportation, and daycare assistance” (Brown et al., p. 258).

Albaugh and Nauta’s (2005) study on college women’s experiences of domestic violence and career decision self-efficacy found that participants perceived conflict negotiation skills as most helpful in minimizing sexual coercion and increasing career decision self-efficacy. The majority of college women (82%) in this study were Caucasian, unmarried, not living with their intimate partner, and between the ages of 19 and 25 years old. The measures used included the Career Decision Self-Efficacy Scale–Short Form (CDSES-SF), the Career Barriers Inventory–Revised (CBI-R), the Conflicts Tactics Scale–Revised (CTS2), and the Mood and Anxiety Symptom Questionnaire–Short Form (MASQ). These measures were used to: (1) “determine the degree to which intimate partner violence was related to career decision self-efficacy” and (2) “determine the degree to which partner violence was related to career barriers” (Albaugh & Nauta, 2005, pp. 296-97). The study found that sexual coercion negatively affected self-confidence and self-appraisal. However, at the same time, the results showed that the women did not perceive any career barriers related to their experiences of intimate partner violence.

Albaugh and Nauta’s (2005) and Brown et al.’s (2000) studies underscored the diversity and complexity of needs among women trauma survivors. More importantly, Brown’s study showed that race and class do matter: minority and low-

income women trauma survivors experience the return to work in different ways than do their white middle-class counterparts. Minority and poor women may have fewer opportunities and resources for participating in postsecondary vocational training and college programs, making them less competitive in a more demanding job market. Vocational rehabilitation and mental health counselors who assist women survivors should assess and identify survivors' individual needs, taking full account of their social, cultural, and economic status and life circumstances.

Facilitators of Employment for Women Trauma Survivors: Community and Treatment for PTSD

Community Awareness and Access to Resources and Support

Several studies on battered women found that the women reported an increase in quality of life as a result of accessing community resources and support systems such as social and legal services (Chronister et al., 2004; Sullivan & Bybee, 1999). The study by Allen, Bybee, and Sullivan (2004) on battered women's needs and effective community advocacy found that battered women who "received comprehensive advocacy were more effective in meeting their needs than women who did not receive such support" (p. 1032). The study's objective was to examine battered women's help-seeking behaviors and identify their needs (for example, education, health care, and employment). The study found that the women participating in the research had diverse needs and showed that "community advocacy intervention enhanced survivors' effectiveness in acquiring needed community resources regardless of the specific set of needs women presented" (Allen

et al., 2004, p. 1029). Sullivan and Bybee's (1999) study, *Reducing Violence Using Community-Based Advocacy for Women with Abusive Partners*, measured the effectiveness of community-based advocacy in reducing domestic violence. Most importantly, the study found that women who worked with community advocates experienced less violence than did women who did not receive advocacy services.

In terms of reducing violence, women survivors benefit from both short- and long-term planning (Chronister, 2006; Chronister et al., 2004; Sullivan & Bybee, 1999). Short-term planning may include securing immediate employment and safe housing and addressing daily living needs. Long-term planning focuses attention on long-term financial independence and security for the survivor and her family.

The article by Chronister et al. (2004) on vocational research for battered women recommended career assessment and exploration for long-term career planning for women trauma survivors. Limited focus on short-term employment needs may not ameliorate the economic strains on women survivors and their families. Long-term planning effectively breaks the cycle of violence, making it less likely that women survivors will return to abusive relationships (Chronister et al.). Moreover, vocational research on battered women "must include examination of counseling strategies and interventions that advance women's vocational and economic attainments over time" (Chronister et al., p. 907).

Chronister et al. (2004) believed that the basic principles in Prilleltensky's emancipatory communitarian theory and approach could inform practice and provide a framework for future research on the vocational needs of battered women. For instance, an important tenet of this theory and approach is that individuals and

communities must share the responsibility of raising social consciousness and awareness to address oppressive social structures and practices. Another critical tenet is that individuals and communities must pursue a high quality of life and achieve their goals. More specifically, this particular principle promotes "...conscious participation of individuals and groups in articulating their needs and working toward their fulfillment" (Sloan, p. 96, 1997).

Emancipatory communitarian objectives and values ardently promote "social justice, self-determination and participation, caring and compassion, health, and human diversity" (Prilleltensky & Fox, 1997, p. 8). This approach provides researchers and practitioners with a useful schema that puts forth salient values and practices supporting women survivors' recovery, return to work, and long-term economic stability.

To achieve successful employment, women survivors should receive support to:

1. Improve their access to resources;
2. Expand their career interests and goals, leading to increased career satisfaction;
3. Support their educational and career potential;
4. Encourage contributions to their communities; and
5. Raise their critical consciousness of the impact of domestic violence in their lives (Chronister et al., 2004).

In other words, Chronister et al. (2004) proposed that women should increase their awareness of the impact of domestic violence. The authors further suggested that

helping professionals who work with women trauma survivors should increase their critical consciousness and awareness of the social, political, and economic realities that disempower and impoverish individuals, families, and communities. Helping professionals should also assess the impact of their own “values, beliefs, and practices” that reinforce oppressive practices and systems that hamper women survivors’ recovery and ability to return to work (Chronister et al., p. 903). Ideally, employers should also become aware of the difficulties facing women survivors and assist in eliminating employment barriers (Chronister et al.).

Although broad in scope and idealistic in vision, Chronister et al.’s (2004) research made a strong case for the use of Prilleltensky’s critical approach. This critical approach aptly speaks to the lived experiences of battered women and provides relevant and helpful insights and interventions for researchers and counselors.

Treatment and Interventions for PTSD in Relationship to Work

Fogarty and Beck’s (1995) article *Work Adjustment for Individuals with PTSD* discussed PTSD and its impact on work adjustment and barriers to successful employment. The authors underscored the importance for individuals with PTSD of learning effective ways to deal with the stress and anxiety triggered by the work environment. In instances of increased anxiety and stress, communication with supervisors and coworkers may become strained. Individuals with PTSD may also withdraw socially and isolate themselves on the job. Cognitive and behavioral interventions can help trauma survivors manage stress and increase functionality on the job. Specific interventions and strategies that assist with work adjustment include

(1) cognitive restructuring strategies that include thought stopping and monitoring techniques; (2) relaxation training; (3) social skills training; (4) role playing; and (5) stress inoculation training.

Myriad treatments that may be helpful in trauma survivors' return to work exist for PTSD symptoms. Fogarty and Beck's article is important because it is one of the few in the literature to address adjustment issues experienced on the job as opposed to issues that arise for individuals with PTSD who are in the process of returning to work. It is important to note that this article does not specifically address the needs of women who have histories of interpersonal violence or their unique experiences of work adjustment and return to work.

Clinical Interventions for PTSD

Treatment for PTSD often includes a combination of psychopharmacology and psychotherapy to control physical and psychological symptoms (Courtois, 2004; Herman, 1997; van der Kolk, 2002). Psychological treatments for PTSD include psychodynamic talk therapy, group therapy, cognitive behavior therapy (CBT), dialectical behavior therapy (DBT), exposure-based therapies (ET), and eye movement desensitization and reprocessing (EDMR).

The various types of psychodynamic therapy, or "talk therapy," focus on interpsychic conflicts associated with the traumatic event(s). Psychodynamic therapies emphasize the "therapeutic relationship, transference and countertransference, and developmental issues" (Cason et al., 2002, p. 311). Cognitive behavior therapy (CBT) helps clients manage and reduce maladaptive feelings, thoughts, and beliefs related to the traumatic event. The objective of CBT is

to help clients challenge dysfunctional belief systems and “bring them into balance” (Cason et al., 2002, p. 308). Dialectical behavior therapy (DBT) was developed by Marsha Linehan (1993) for the treatment of borderline personality disorder (BPD) (Courtois, 2004). Studies have found that women diagnosed with BPD often report histories of childhood sexual abuse (Herman, 1997; McLean & Gallop, 2003; Murray, 1993). DBT comes under the umbrella of cognitive behavior interventions. Individuals with borderline personality disorder have chronic histories of unstable relationships, negative self-images, and poor emotion and impulse control (Swensen et al., 2002). Individuals with BPD may also experience depression, anxiety, posttraumatic symptoms, substance abuse, and/or eating disorders. DBT addresses individuals’ emotional vulnerability and past invalidating environments. DBT group treatment improves self-image, emotional regulation, and interpersonal and communication skills. DBT therapists use a range of clinical interventions that include cognitive restructuring and exposure procedures.

Exposure therapy (ET) uses systemic desensitization and flooding to help individuals process traumatic events. These techniques reduce anxiety and phobias by allowing clients to safely re-experience negative and fearful feelings associated with the traumatic event (Cason et al., 2002). Re-experiencing memories facilitates the “habituation of the anxiety surrounding the traumatic event” (Cason et al., p. 307). The re-experiencing process permits the introduction of new and adaptive cognitions, thoughts, and feelings around feared events and situations (Cason et al.).

The eye movement desensitization and reprocessing (EDMR) technique developed by Francine Shapiro also reportedly helps clients process traumatic

memories. The EMDR procedure is based on lateral eye movements that help with adaptive processing of the traumatic memories (Cason et al., 2002).

A range of treatments and interventions exist to treat PTSD. However, it is unclear whether PTSD clinical interventions and treatments alone facilitate recovery (Harvey, 1996). Researchers (Allen et al., 2004; Brown et al., 2000; Chronister et al., 2004; Gianakos, 1999) have recommended a comprehensive approach that includes treatment and community services that assist women survivors with recovery and return to work.

Career Decision Making and Vocational Counseling

Career Decision Making

Career decision making is an important component of a successful return to work for women trauma survivors. Vocational assessments/evaluations and career exploration are critical to women survivors' successful transitioning into the world of work (Chronister, 2004; Gianakos, 1999). Abused women may make career selections based on otherwise socialized stereotypical or traditional sex roles (Gianakos, 1999). Gianakos (1999) argued that women survivors may view themselves in the nurturing role and may select careers that are typically lower-paying caretaking jobs (for example, health care assistant or nursing aide).

One of the key factors in a successful return to work is the "fit" between women survivors and their work environments. A central construct of Dawis and Lofquist's (1984) theory of work adjustment is that success on the job results from a good fit between individuals and their work environments. Dawis and Lofquist noted

a good “fit” when correspondence, mutual responsiveness, and satisfaction existed between the individual and the work environment. This theory underscores the importance of good career decision making and vocational planning.

A few existing studies have utilized career counseling models, social cognitive theory, liberation theory, and empowerment models as frameworks to assist women survivors with the process of returning to work (Albaugh & Nauta, 2005; Chronister et al., 2004; Gianakos, 1999). These theories and models help frame and identify women survivors’ psychological, educational, and vocational needs. Gianakos outlined Solomone’s five-stage career counseling model in her paper “Career Counseling with Battered Women.” Solomone’s career counseling model identified a range of needs in terms of recovery and successful return to work. The five stages include (1) understanding the self, (2) understanding the world of work, (3) understanding the decision-making process, (4) implementing educational and vocational decisions, and (5) adjusting to the work or school environment (Gianakos, pp. 4-10). Gianakos argued that Solomone’s five-stage career counseling model is an effective developmental framework because it is “process-oriented” and holistic in its approach and application.

Chronister and McWhirter (2003) outlined effective uses of social cognitive career theory (SCCT) and McWhirter’s 5 C’s empowerment model for women trauma survivors returning to work. The SCCT theory and 5 C’s empowerment model address the psychological, social, and career barriers experienced by women survivors. McWhirter’s 5 C’s empowerment framework outlined five variables critical to a successful return to work for women trauma survivors. The five variables

are: (1) collaboration, (2) context, (3) competence, (4) critical consciousness, and (5) community. According to Chronister and McWhirter, career counselors should “facilitate critical reflection and awareness of the power dynamics at work in battered women’s lives; facilitate the recognition, enhancement, and use of the skills and resources these women have; and, ultimately, facilitate the ability of these women to contribute to the empowerment of others” (p. 422).

The five variables of McWhirter’s empowerment model are constructive guides that can be used by vocational rehabilitation counselors and other professionals who help women survivors return to work. For example, in the case of the context variable in the empowerment model, counselors’ awareness of the social, emotional, and economic consequences of interpersonal violence would help identify specific barriers to employment for women survivors.

Career Decision Making, Self-Efficacy, and the Return to Work

A number of studies covering battered women, career development, and work argue that self-efficacy is a critical component of career decision making and a successful return to work. Battered women’s career decision making shows a strong relationship between higher self-efficacy and good career decision making (Brown et al., 2000). Self-efficacy is a concept rooted in Bandura’s social learning theory and can be understood as an individual’s “core belief that one has the power to produce desired effects by one’s actions” (Benight & Bandura, 2004, p. 1131). Betz (2005) described career self-efficacy in terms of women’s career development as a “cognitive appraisal or judgment of future performance capabilities” (p. 6). Studies

also have shown that higher career self-efficacy increases risk-taking behavior (Brown et al., 2000; Betz & Hackett, 2006).

Albaugh and Nauta's (2005) study on college women ages 19 to 25 years who experienced intimate partner abuse found that résumé therapy and negotiating skills had a positive effect on career self-efficacy. This exercise also provides an opportunity to evaluate women's strengths, skills, and interests. The process of creating and writing a résumé allows individuals to organize and view their skills and accomplishments. Albaugh and Nauta's study found negotiating skills invaluable to women's career decision making and work adjustment. Women who practiced these skills were able to assert themselves more effectively and communicate more effectively with their significant others. They were also able to use the art of compromise to manage conflict within the workplace (Albaugh & Nauta, 2005).

These study results show that comprehensive approaches that assist women survivors with recovery and the return to work are most effective when they:

(1) Address the consequences of domestic violence, and

(2) Help women engage the world of work (Brown et al., 2000; Chronister & McWhirter, 2003; Chronister et al., 2004; Gianakos, 1999).

Summary

A clear need exists for additional research that addresses women survivors' needs in successfully returning to work. This study focused on women survivors' self-reports of barriers to and facilitators of employment and asked women about their

experiences of vocational rehabilitation and mental health counseling within the context of returning to work.

Research exists on other populations of women trauma survivors returning to work. For example, Brown et al. (2000), Chronister et al. (2004), Chronister and McWhirter (2003), and Wettersten et al. (2004) looked at career decision making and the return to work for battered women living in domestic shelters. Other researchers, such as Albaugh and Nauta, examined the career decision making of college-age women who experienced intimate partner violence, and Gianakos completed a study on career counseling interventions with women survivors enrolled in college or training programs. Other literature, such as Fogarty and Beck's article on PTSD and work adjustment issues, addressed individuals with PTSD but did not specifically address the complexities of how psychological trauma affected women with histories of interpersonal violence. This study aimed to fill a void in the existing research and literature by making central the lived experiences of women trauma survivors who (1) are living independently and not living in domestic shelters; (2) are no longer living with an abusive partner, caregiver, or relative; (3) are not enrolled in college; and (4) have or had in the past steady employment (Chronister et al., 2004).

The research done by Brown et al. (2000), Chronister et al. (2004), and Gianakos (1999) offered important studies that empowered and gave voice to battered women's experiences of returning to work. These researchers supported comprehensive approaches that promote women's recovery and engagement in career exploration, career decision making, and job search activities. Prior to this study, no studies had (1) specifically examined the interface and collaboration (or lack thereof)

between mental health and vocational rehabilitation counselors assisting women survivors in returning to work, or (2) focused attention on the return to work for adult women survivors who live independently in the community, are underemployed, or had a career and are actively engaged in the vocational rehabilitation process.

CHAPTER THREE

METHODS

Introduction

This feminist qualitative study explored women trauma survivors' experiences in returning to work through semistructured interviews. Women survivors were asked about their perspectives and experiences in returning to work in order to: (1) capture their mental health and vocational rehabilitation counseling experiences within the context of work, and (2) identify factors that are limiting to and facilitative of the return to work. The data was then analyzed for recurrent and emergent themes.

Using a Feminist Perspective to Examine Women Trauma Survivors' Return to Work

A feminist approach provides an important and unique perspective from which to analyze and capture the intricacies and interplay of gender and work within larger social, cultural, and interpersonal contexts. Ecological perspectives and models provide a useful framework by which to understand the impact of interpersonal violence on individuals and communities (Harvey, 1996). Unlike feminist perspectives, however, ecological models do not make gender central in their analysis. A feminist perspective places women at the center within their respective social, political, and cultural contexts (Harvey). Integrating a feminist perspective leads to a better understanding of the relationship between interpersonal violence and work within larger contexts of systemic and institutional forms of violence and

maltreatment. Some examples of systemic and institutional violence are racism, sexism, ablebodiedism, ageism, and homophobia. A feminist mode of analysis makes primary the interaction between women's experiences and the mutual influences of institutional, social, and cultural contexts (Hartsock, 1998).

A fundamental objective of feminist research is to improve the quality of life for women. Hartsock (1998), a well-known feminist standpoint theorist, asserted that "the power of a feminist method grows out of the fact that it enables us to connect everyday life with an analysis of the social institutions which shape that life" (p. 36). In other words, feminist research should not just inform, but instead be transformative and empowering for, those who participate (Hartsock, 2003).

A Feminist Mode of Analysis

A feminist mode of analysis makes women's experiences central to this study. My method will include the following: (1) contextualizing the analysis and interpretation; (2) valuing subjectivity and self-definition; and (3) making transparent the interdependence between researcher and subject (Collins, 1991; Gergen, 1988; Harding, 1991; Hartsock, 2003).

Using feminist principles as a guideline for research accomplishes the following: it gives human subjectivity prominence, acknowledges power dynamics, and supports reflexivity, or a co-construction of meanings between researcher and participants. Positivistic research, on the other hand, attempts to isolate the human condition from "larger social, economic, and political currents" (Harding, 1991, p. 162).

Using Feminist Methods in Qualitative Research

Feminist qualitative research affords women a safe realm within which to tell their stories and supports the position that women are capable of “making sense of their lives” (Hallstein, 2004, p. 37). This capability affords women critical agency to tell their stories in their own words. Women are validated and empowered when they tell their own stories.

Speers (2002) posited that feminists prefer “qualitative social scientific methods such as semistructured or unstructured interviews” over quantitative methods (p. 784). Weingraf (2001) noted that personal interviews as a qualitative method are “designed for the purposes of improving knowledge” (p. 3). This qualitative method improves knowledge of analysis because of its particular analytical component. This analysis offers women the opportunity to “deconstruct their lived experience” and assume power by telling their stories (Campbell & Wasco, 2000, p. 773).

Feminist qualitative researchers support the perspective that the “scientist/researcher” is not a “neutral conduit” and therefore cannot achieve “uncontaminated” levels of objectivity (Speer, 2002), suggesting that researchers’ experiences and perceptions of the world ultimately inform, shape, and guide the direction of their projects.

Feminist understandings of reflexivity in research make transparent issues of power in the relationship between “researcher and researched” (Mauthner & Doucet,

1998). It brings to light researchers' social location and position as they relate to participants' social location and positioning. This transparency acknowledges the inequity of power between researcher and participant. The nature of the relationship between researcher and participant grants more power to the researcher and has a direct impact on the study's development, direction, and final analysis. Feminist qualitative research acknowledges the inherent and unequal power dynamics between researcher and participants. When conceptualized, "co-production" is a reflexive process that produces shared meanings and new insights (Collins, 1991).

Researcher's Positionality and Self-Reflection

My lived experience takes shape via my social location, ethnicity, gender, and socioeconomic status and, because I am the researcher of this study, ultimately influenced this study's direction, interpretations, and analysis. Given the nature of the study and the use of a feminist methodology, a short description of my background is in order to make explicit the lens I bring to the project.

I have long understood my social world as one in which the social, political, and cultural realities of race, class, and gender interlock. I believe feminist and critical theories best speak to my experiences as a woman and working-class biracial person of color. From my perspective, feminist and critical theories do the best job of considering the complexities of gender, race, and class within a social context.

I grew up in Boston in the 1960s and 1970s, at a time when racial strife and social change were very much a part of the social, political, and cultural landscape. This was a period in U.S. history during which battles over school desegregation,

civil rights, and the Vietnam War were fought in the streets as well as in the courts.

It was also a time during which women and African Americans made critical inroads in gaining equal access to education and employment.

My mother is of Russian, Irish, and West Indian descent and is identified as Caucasian. My father's family came to the U.S. from Barbados, West Indies in the 1940s. My mother and father were both politically progressive and enlightened. After the death of my father when I was a child, my mother, my younger sister, and I moved to a public housing development in a suburb outside of Boston. My mother, early on, imparted to her two daughters the importance of education and work. She believed that education was the great equalizer, particularly if you were poor and had limited resources; a college education, in her view, could afford poor women and African Americans the possibility of satisfying career choices and substantial employment.

I am fortunate to have meaningful and substantial employment and the opportunity to earn a graduate degree and pursue a doctorate in counseling psychology. My journey, however, has not been free of encounters with insidious forms of racism, sexism, classism, and homophobia. These encounters, along with other of society's prejudices and "isms," diminish quality of life and have the potential to damage one's sense of safety, self-concept, and self-confidence.

Through education and life experience I have developed a keen awareness and understanding of the oppressive effects of racism, classism, sexism, and homophobia. My work and career have provided me with financial security, purpose, and a connection to community. My work, education, and training have been empowering

and helped me find a voice and venues with which to articulate my perspectives and insights.

Based on my personal and professional experiences, I believe that education and substantial employment can ameliorate the destructive and debilitating psychological effects of interpersonal and institutional violence. Moreover, I believe that education and substantial employment increase women's self-esteem and confidence, offer a connection to community, and break the cycle of violence, thereby affording women important financial security and independence.

How I became interested in this topic has much to do with my years of experience working as a vocational rehabilitation counselor and mental health trainee. I have worked as a VR counselor for the Massachusetts Rehabilitation Commission for over 20 years, assisting individuals with disabilities in returning to work. While a graduate student, I worked as a mental health trainee with women trauma survivors at the Cambridge Hospital's Victim of Violence program.

From my experiences working with women survivors I found that many of these women have difficulty returning to work, including women who receive both mental health counseling and vocational rehabilitation counseling. Some of these difficulties include debilitating complex PTSD symptoms, inadequate health care and treatment, significant gaps in employment, and limited job skills and training. These difficulties pose significant barriers to employment and led me to this inquiry into how women survivors perceive factors that both limit and facilitate their successful return to work.

This project was designed to allow women to speak in their own words about what helps them return to work. This project aimed to validate and empower women while recognizing them as experts on their own experiences. My own long and difficult pursuit to gain admission to Northeastern's doctoral program has afforded me the knowledge, education, and credentialing critical to the development of this project. The process of bringing to life this project has brought me a deep sense of purpose, satisfaction, and validation. It is my hope that this project will inspire discussion and debate and stimulate additional research on women, trauma, and the return to work.

Participants

This study included 15 women participants who have histories of interpersonal violence, have a primary diagnosis of PTSD, and receive vocational rehabilitation services from the Massachusetts Rehabilitation Commission. The participants included women ages 25 to 65 who come from different ethnic and socio-ethnic backgrounds. Additionally, vocational rehabilitation counselors referred all participants.

Sources of Data

Semistructured Interview

The semistructured interview consisted of seven questions. The interview questions elicited participants' responses about their experiences in returning to work. The researcher used three different data sources to develop the constructs of interview questions and language. The first source was the researcher's extensive experience in

vocational rehabilitation and mental health. The second source comprised consultations with vocational rehabilitation counselors and mental health professionals who work with women trauma survivors. The researcher consulted professionals on the questionnaires' constructs, relevance, and language. The third source came from discussions with women trauma survivors who were receiving vocational rehabilitation services. Additionally, the researcher performed a pilot interview with a woman trauma survivor to help structure, develop, and identify the questionnaires' constructs and language.

Demographic Questionnaire

Participants completed a questionnaire that included interviewees' age, race, marital status, education, income, and employment status (available in Appendix A).

Procedure

Participants for this study were referred by vocational rehabilitation counselors that work for the Massachusetts Rehabilitation Commission (MRC). Vocational rehabilitation counselors from the Somerville, Roxbury, Quincy, and Boston offices were notified of the objectives and goals of this project and asked to refer potential participants. Once the MRC granted permission for project participation, the researcher contacted MRC Area Directors and arranged a meeting. At this meeting the researcher communicated the objective, goals, and selection criteria. The Area Directors then communicated and promoted the study to vocational rehabilitation counseling staff in one or more of the following ways:

1. Discussed the details of the project in a staff meeting.

2. Wrote an interoffice memo about the details of the study.
3. Distributed fliers to VR counselors with description and background information (enclosed in the packet), with permission from Area Directors.

The study gathered 15 volunteer participants via the following methods:

1. VR counselors contacted potential participants and gave the names and phone numbers to the researcher.
2. VR counselors provided potential participants with an informational flier (enclosed in packet) in person or via mail, after which the potential participants contacted the researcher directly.

When telephone contact occurred between the researcher and potential volunteers, the researcher described the intent of the study, the nature of participation in the project, and the risks and benefits of the study. This contact via telephone helped determine whether potential volunteers met the study's selection criteria and whether the volunteers had adequate command of the English language for the purposes of participation in the semistructured interview. The researcher asked the VR counselors to contact potential volunteers within a month of notification of the study and inquire whether they would like to participate in the study. The VR counselors provided the names and numbers of interested participants to the researcher. Within a week of receiving names and numbers, the researcher contacted interested participants. The participants received options as to the location of the interview. This approach addressed participants' sensitivities concerning issues of confidentiality and power related to the researcher's roles

and position as a doctoral student and employee of the MRC. Participants received the following options:

- Interviews could take place in MRC area offices.
- Interviews could take place in local educational institutions, public libraries, and/or community centers, depending on availability.

The researcher audio taped the interviews and later transcribed them. The interviewer transcribed the taped interviews verbatim; she then reviewed the transcriptions and field notes.

Informed Consent

The researcher obtained informed consent from participants before they completed a demographic questionnaire and commenced with the interview. Great care was taken to ensure that participants completely understood the consent agreement before signing. The interviewer and participants thoroughly reviewed the consent agreement in both verbal and written form. The interviewer also verbally outlined the risks and benefits of this study and ensured that participants had an opportunity to ask questions. The interviewer also made clear that the potential participant was free to participate or not without negative consequences, and that the participant could quit at any time. Participants received a copy of their consent form, which also included contact information should they have other questions or concerns. Before the start of the interview, participants completed a demographic questionnaire that obtained interviewees' age, race, marital and employment status, and income; this questionnaire took approximately ten minutes to complete. The

interview consisted of seven questions and lasted approximately one hour. At the end of the interview, interviewees received financial compensation in the form of \$25.00 in cash for their participation. The researcher asked some interviewees to participate in a follow-up individual interview to discuss emerging themes generated during the interview. The follow-up interviewees were chosen randomly.

The researcher preserved confidentiality, not sharing the information gathered from interviews with anyone. This study did not access additional information from MRC counselors or individual case files. The researcher gathered all relevant information through participant interviews and questionnaires. Only the research team had access to the interviews and questionnaires. The transcriptionist employed to transcribe the audiotapes knew of the requirements for confidentiality. The researcher analyzed the transcriptions and removed the names in the transcripts, replacing them with identifying numerical codes assigned to the 15 participants. At every point during the analysis, the researcher masked all identifying information. Members of the research committee responsible for the reliability check also reviewed individual references to make sure that no identifying information appeared. After data analysis, the transcriptions of the audiotaped interviews and other sensitive information pieces were destroyed. All data generated in the course of research were locked in a secure location at the researcher's residence. The identities of the participants remain undisclosed. Any references to participants' identities that would compromise their anonymity were removed prior to the preparation of research reports and publications. The data may be used in future research.

The primary investigator/researcher is a doctoral student in the Northeastern University Counseling Psychology program. This study is part of a dissertation to fulfill the requirements for completion of doctoral program. The primary investigator is also a vocational rehabilitation counselor and employee of the Mass Rehab Commission Somerville Area Office.

Risks and Benefits

The risks were minimal. While the participating individuals have suffered trauma, this population of participants was at minimal risk because the selection criteria in the procedure ensured that they were functional in terms of their recovery and capacity to return to work. The researcher took steps to protect confidentiality. If at any point in this study a participant showed or expressed emotional distress, the interview ended without negative consequence to the participant. If the interviewee wanted to quit and needed assistance leaving the interview site, the researcher made contacts and/or referrals to the appropriate person(s).

Data Analysis

This study's analysis of the data was qualitative. The researcher systematically analyzed the data generated from the transcriptions for emergent and recurrent themes. The researcher also repeatedly analyzed and reviewed the interview transcriptions and field notes. The researcher used demographic information from the participants' biographical questionnaires to help clarify women's stories of returning to work. Moreover, the data from the participants' demographic life circumstances aided in examining themes from the participants' stories. The researcher integrated

demographic data and analyzed it with the data generated from the interview transcriptions.

The study employed Lindlof's (1995) stages of analysis to help "capture the essence of the participants' experiences" (Dougherty, 2001, p. 379). This process organized and analyzed emergent themes and involved two steps of analysis: reduction and explanation. Reduction involves the sorting, labeling, and/or categorization of emergent themes. Explanation involves the development and integration of first- and second-order explanations. First-order explanations are participants' subjective "accounts" and/or "interpretations" of particular situations or events (Lindlof, 1995, p. 217). Second-order explanations include the researcher's own interpretations and/or "meaning making" of participants' accounts and interpretations (Lindlof, 1995). Recurrent themes are generated, identified, categorized, and analyzed from participants' responses to the seven interview questions. The researcher reviewed the transcriptions repeatedly and checked for such recurrent themes. Member checks "to determine the accuracy of the findings" were obtained from between 3 and 5 participants (Creswell, p. 196, 2003). The researcher asked the participants to take part in a follow-up individual interview to discuss emerging themes generated during the interview. The researcher randomly chose the follow-up interviewees and asked two peer experts to check the accuracy of the data and consistency of the thematic analysis.

CHAPTER FOUR

RESULTS

Overview

Chapter four presents the demographic information for the 15 women who participated in this study, along with a sample of the biographical histories of 4 of the women. It also presents the study's findings through recurrent and emergent themes generated from responses to the seven interview questions. Recurrent themes are generated from the ideas expressed in many of the women's stories. Emergent themes are unique perspectives that may be articulated by a few women or by only one woman. Lastly, the chapter discusses my impressions and participant reactions.

Demographic Information

Demographic information was collected on all 15 women who agreed to participate in the interview and who had histories that included trauma, mental health counseling, and vocational rehabilitation counseling. The women's case histories were summarized as well. Participant ages ranged from 38 to 61, with a mean age of 50. One woman was age 38, six women were between the ages of 41 and 49, six women were between the ages of 50 and 56, and two women were between the ages of 60 and 61. Of the participants, 11 women identified themselves as White, 2 identified themselves as African American, 1 identified herself as Latina, and 1 identified herself as of mixed ethnic origin. Of the participants, 8 had children. The children's ages ranged from 13 to 40. Marital/relationship status included 7 women who were

single and 8 who were separated and/or divorced. Highest level of education achieved ranged from high school to a law degree. Of the participants, 8 had completed high school, 2 had completed postsecondary education in the form of a certificate and/or vocational training, 1 had completed an associate's degree, 2 had completed a bachelor's degree, 3 had completed a graduate degree, and 1 had completed a law degree. Employment status included 2 participants working part-time, 1 participant working part-time and receiving disability benefits, 9 participants receiving disability benefits and not employed, 2 who were not employed and were receiving other forms of public assistance, and 2 reporting no income. Below are 4 biographical participant histories that are representative of the sample. The other 11 biographies are located in the appendix.

Shelly is a 50-year-old single Caucasian woman who currently lives in a city north of Boston. Shelly has a graduate degree and currently volunteers as a housing advocate for low-income individuals and families. She has been doing this volunteer work for the last ten years. She has held paid positions. One of the paid positions she held was at a vintage clothing store. She worked part-time at the clothing store but found the job physically taxing and emotionally demanding. She had particular difficulty managing social interactions with customers. She spoke about her experiences in a somewhat detached and matter-of-fact manner, but clearly described the multiple "obstacles" she has faced that were related to her vocational rehabilitation and return to work. Shelly has a history of childhood abuse, has been "severely anorectic," and reported being "hospitalized many times" over the course of her life. She has been in individual therapy for decades and believes therapy is

"incredibly important" and has helped her "learn how" and "want to take care of herself" so she can have a "fuller life." Shelly is also a cancer survivor and because of surgery, radiation, and chemotherapy treatments has been unable to work for extended periods. She described her recovery from breast cancer and radiation treatments as being a key obstacle to employment. As a result of her radiation treatments she developed "a lot of skin problems" that have made her feel "self-conscious" and negatively affected her ability to speak in public, which is central to her role as a community advocate. However, Shelly presents as an extremely articulate, thoughtful, and politically astute woman and is eager to continue her housing advocacy work with low-income individuals and families. She discussed at length her recovery, offering insights into the personal, social, and institutional barriers and obstacles she and other women survivors experience when returning to work.

Corrine is a 54-year-old African American single mother of nine children whose ages range from 13 to 38. She currently lives in a city in the Northeast with six of her children. Corrine is a high school graduate and is currently participating in a college internship at an inner-city program for ex-offenders and families. She reports liking her past jobs but is "loving school more." Before her neck injury and her return to school, Corrine worked as a certified nursing assistant, as a home health and day care assistant, caring for the elderly and children. She enjoyed direct care and found it "rewarding." Corrine is no longer able to do this type of work because she has arthritis and is no longer able to lift and pull things. She finds taking public transportation difficult if she has to stand for long periods. Corrine is a victim of

domestic violence. Her abuser still lives in her community. She is committed to her treatment and recovery, participates in individual and group therapy, and takes medication to reduce symptoms of depression and anxiety. She has worked hard to overcome what she describes as debilitating "anxiety attacks." She still worries about "getting used to goin' out in the streets again" and "feelin' comfortable enough to be able to travel without worryin' about somebody hurting you." In the past, she felt as though she was always "lookin' over my shoulder, and I had to keep my back to walls and things like that." She admits generally experiencing difficulty being around "male peoples." Working with male offenders sometimes makes her feel "uncomfortable," and as a result she has difficulty "focusing" at work. She also reported that "anxiety attacks" were less of an issue in home health care positions because "you go in the home and it's just you and the person, so therefore you don't have to worry about, uh, always feelin' like somebody's gonna come up on you, or somethin' like that." However, she believes that her anxiety is "gettin' better." Corrine presents as a woman who is committed to her recovery and rehabilitation despite a lifetime of abuse, neglect, poverty, and addiction. She states that she gets most of her emotional support and encouragement from her children. She has chosen a career in counseling others, such as male offenders, who are mostly people of color and also have been abused, neglected, discriminated against, and marginalized by our society at large.

Carla is a 38-year-old divorced Caucasian woman who is currently living in transitional housing in a Northeastern city. She was born and raised in a New England suburb. At age 15, she was date raped. As a result, she became pregnant and raised a son, who is now 23 years old. After graduating from high school she earned a

cosmetology certificate and worked for many years as a licensed hairdresser. Carla believes that hairdressing and cosmetology have always been her "strength," and eventually she went on to manage her own business. She describes herself as an "overachiever." Carla has held other jobs that include child care, elderly care, waitressing, bartending, landscaping, house painting, assembly, and packaging. She is currently not employed and is participating in a training program to become a personal trainer. She is currently living on public transitional assistance and receives food stamps and a "\$60 stipend a week" and claims that she's "just barely gettin' by." She believes that by furthering her education she will be better able to support herself and stated frankly that "without education there's not gonna be any money." Carla has a long history of substance abuse and addiction. She is currently living in a sober house and program that provides individual and group counseling for substance abuse and depression. Carla is also being treated for Hepatitis C. Before coming to the sober house, Carla was incarcerated for felony and habitual DWI (driving while intoxicated) and reports being homeless for significant periods. Carla presented as a straightforward, engaging, open woman from a working class background. She seemed eager to participate in the interview. Her story was compelling, as were her insights about her life within the context of trauma and recovery. She candidly described the many ups and downs related to her addiction and subsequent relapses. She eventually lost her hairdressing business and her cosmetology license due to her drug addiction. She states that instead of "losing it" she "basically gave it up" and kept "falling short" because of her drug addiction. Now she is committed to her sobriety and much more aware of the pitfalls of addiction, viewing it as a "three-fold

disease," a disease that negatively affects her "mental, spiritual, and physical" health and well-being. Carla seems generally hopeful and optimistic about her future. She is currently speaking to women in prison about her experiences. She stated, "So like right now I'm goin' into the Department of Corrections, [but] instead of going in there in shackles, I go in there and I speak with the women."

Louise is a 61-year-old Caucasian divorced mother of three adult children aged 35 to 40. She currently lives alone in a public housing development. She was a victim of childhood abuse and domestic violence and is currently receiving individual and group therapy. Two of her sons struggle with substance abuse. During the interview, particularly when discussing her sons, she became emotional and tearful. She openly expressed her heartbreak and concerns about her youngest son, whom she described as a "heroin addict" who "ended up a-goin' the way of drugs and prison." Her middle son went to college but was unable to finish because of symptoms associated with depression, and as a result became homeless and addicted to marijuana and crack cocaine. Despite the pressures and stresses of a tumultuous family life, up until two years ago she worked full-time to support her family. Her first husband was an alcoholic and did not provide adequate financial support to the family. When her mother was alive, she "used to always give me a couple of bucks...to get food for the kids and stuff." After her mother died she "couldn't depend" on her husband. She stated, "By the time he got home at night I just didn't know what money he had left..." Eventually, she and her first husband divorced after 25 years of marriage and after he found "himself a younger girlfriend." Louise remarried a few years later to a man she described as unsupportive and verbally

abusive. She eventually left the marriage and has not remarried. Louise has a long and steady employment history and is interested in enrolling in a college program. Louise reported growing up poor and having to work while in high school to support the family. She was employed as a factory worker, health care assistant for the elderly, file clerk, and secretary. Her last position was working as a file clerk for an eye doctor. She worked for the doctor for 26 years. She left the position 2 years ago because of the increasing abuse she experienced on the job. Louise was devastated and attributed her leaving to "depression" and her inability to withstand the constant abuse and harassment from her boss: "I knew I had to leave, it got so bad . . . he started yellin', screamin' at me, screamin' at me . . . I left that place, too, tellin' him I was depressed." The humiliation and devaluation from her boss had occurred over many years. She described the relationship with the doctor as "like a marriage" and said, "I've done everything but screw the guy." Her boss would "yell" at her in front of the other secretaries. She was often excluded from office celebrations and training opportunities and attributed this to her age, lack of education, and socioeconomic background. She was also denied promotional opportunities and "was kept in the back room a lot, and he had the . . . blond with all the jewelry on as, as the receptionist." She believes that some of the abuse and mistreatment she experienced on the job took place in "subtle" ways:

Like, uh, but it's so subtle that you know it's like gettin' hit in the side of the face, and you just say, "Did somebody hit me?" You know what I mean? "Hey, he just put me down!" you know? And uh, it's, it's hard to get outta

there, like people my age, you've been doin' it for so, you've had it for so many years, you know, you just don't even know...

Louise described conflicted feelings about her boss because on the one hand he and his wife knew about her background and family life and provided her with an opportunity to learn new skills so that she could financially support herself and family. She took the job mostly out of "survival" and believed it was a good decision at the time because the job "was very prestigious" and "the money was good." Louise is not working at this time and manages to live on disability benefits. She is exploring different career options and is focused on her treatment and recovery. She is currently participating in a dialectical behavior therapy group that addresses interpersonal skills and developing healthy boundaries. She finds DBT strategies helpful and is working on her interpersonal "boundaries" to help her on the job and with "all aspects" of her life.

Introduction to Findings

This chapter examines the women's descriptions of and reflections on successful and difficult experiences within mental health counseling and vocational rehabilitation assistance. Facilitators and barriers to employment are also explored. This chapter also aims to answer this study's four central research questions. They are: (1) How do women trauma survivors perceive and report their work histories? (2) What are the mental health counseling experiences of women trauma survivors who are returning to work? (3) What are the vocational rehabilitation counseling experiences of women trauma survivors who are returning to work? and (4) What

factors do women trauma survivors perceive as facilitators and barriers to employment? In addition to the research questions, this chapter also includes a section analyzing three additional interview questions that asked women about (1) factors they had to consider in making decisions about returning to work; (2) what they would tell professionals; and (3) what they would say to other women about what might be helpful to their vocational rehabilitation processes.

Research Question 1

How Do Women Trauma Survivors Perceive and Report Their Work Histories?

Table 1

Question 1: How Women Trauma Survivors Perceive and Report Their Work Histories

Successful work experiences	Difficult work experiences
<p><i>Recurrent themes</i></p> <p>Work environment and job satisfaction</p> <p style="padding-left: 40px;">Cooperative work environments</p> <p style="padding-left: 40px;">Autonomy and independence</p> <p style="padding-left: 40px;">Defined work roles and responsibilities</p> <p style="padding-left: 40px;">Good fit—interests, skills, and aptitudes</p> <p style="padding-left: 40px;">Promotional opportunities and positive feedback</p> <p>Meaningful work connection and helping others</p> <p><i>Emergent themes</i></p> <p>Employer sensitivity and awareness of domestic violence</p>	<p><i>Recurrent themes</i></p> <p>Hostile work environment</p> <p>Unclear boundaries and roles</p> <p>Job incompatibility and poor fit</p> <p><i>Emergent themes</i></p> <p>Anger and frustration</p>

Successful Work Experiences

Participants were asked to discuss work experiences they perceived as successful and/or difficult. A recurrent theme voiced by many women was the importance of healthy work environments to job satisfaction. Other participants reported jobs that helped others and connected them to the larger community as successful work experiences. An interesting and emergent theme described by one woman was the positive influence of her employer's awareness and sensitivity to her history of domestic violence.

Work Environment and Job Satisfaction

Women in the study reported satisfaction in jobs and work environments that (1) were cooperative; (2) had defined work roles and responsibilities; (3) were a good fit relative to their interests, skills, and aptitudes; (4) allowed a degree of autonomy and independence; and (5) provided promotional opportunities and positive feedback.

Cooperative work environments.

Women reported that they were more satisfied with jobs that had a cooperative work environment and in which they worked as part of a "team." Jen referred to a position working as a surgical tech in a hospital in a midwestern city as a successful work experience. She described the people she worked with as supportive and stated that they worked well together as a team. The work environment was less hierarchical than others she had experienced; she received good supervision and had opportunities to learn new skills on the job. Molly worked as a residential assistant at a group home for adults with disabilities. She also reported enjoying working as part of a "team" and at the same time favored working independently.

Autonomy and independence experienced on the job.

The women reported increased satisfaction in jobs that afforded them some autonomy and independence. Louise worked in factories doing soldering and assembly work. She enjoyed this type of work because it allowed her to work independently, and she preferred to be "left alone to do my work." The job also paid well enough to help support her family and finance school. Corrine worked as a home health aide with the elderly and found it "rewarding;" she enjoyed working independently and valued working autonomously. "You don't have to worry about nobody bein' over you . . ." Corrine is a survivor of domestic violence and struggles with trauma-related panic attacks. Working as a home health aide provided a work environment that she enjoyed and in which she felt safe. She "didn't worry about... always feelin' like somebody's gonna come up on you."

Defined work roles and responsibilities.

One participant believed that her job as a public attorney working with low-income families was a successful work experience. She enjoyed working autonomously and benefited from clear structure and defined responsibilities and roles.

I enjoyed the travel, the freedom, the autonomy. I really, I really liked that, which is interesting, 'cause . . . there was a lot of structure in that, you, uh, had certain responsibilities as a lawyer, on a case, so there was a role, and definition.

Good fit relative to women's interests, skills, and aptitudes.

One participant, Carla, believed that her job as a hairdresser was a good fit because she was able to utilize her skills, aptitudes, and interests. "Not only was I good at it, but I liked it, and I think it's important to have both of those things."

Promotional opportunities and positive feedback.

Women reported successful work experiences when they received positive feedback and promotional opportunities. Mary worked as a waitress at a family restaurant where she enjoyed the patrons and work environment. Mary considered this a successful work experience because of the promotions she received. Francis worked as a mental health assistant as part of an internship for school. Francis believed this was a successful work experience because she received positive feedback from her clients and coworkers:

The clients gave me the feedback that I was doing a good job, and my counselors are as well. Um, and that, you know, that enabled me to want to come to work each day, see, to, you know, to get the, um, job done that I had to do, and the duties that I had to carry out. Um, I think without that . . . I wouldn't have cared to participate in the program.

Meaningful Work through Connection and Helping Others

The women in the study reported meaningful work experiences as an important component of successful work experiences. The participants believed that meaningful work included helping others and work that connected them to the larger community. Christine believed that her work as a psychotherapist really "mattered" and stated that she "really cared about the people." She discussed the strong

connections and relationships she had developed with her clients. Sandy described her job as an attorney working with children and families at a nonprofit care program. She believed that this job was meaningful because she "was making a difference in the lives of...children and adults who were touched by abuse." Carla reported that hairdressing and cosmetology made her feel "rewarded" and "good" because she "helped other people feel good and look good about themselves."

Employer Sensitivity to and Awareness of Domestic Violence

Candis reported her current job as a successful work experience because her employer allowed her to take leave time so she could find safe housing, get treatment, and pursue other community assistance. She was able to disclose to her employer that she was a victim of domestic violence.

And um, prior to the year and a half I was on a medical leave, and um, for about a year and a half, and I will say that my employer was very good in allowing me to take the time off, because it was in fact, um, um, the time I needed to, um...seek, uh, some extra assistance; medical assistance, counseling, um, social services, and so forth, regarding, um, a relationship that I was in, um, that was not good. And um, so that's one good thing about the job, is that these people were allowing me to take the time off to get situated. I, I did find new housing, and um, I moved to a different city, and um, but I kept, I kept my employer.

Difficult Work Experiences

The women participants were asked about difficult work experiences. Recurrent and/or common themes included hostile work environments, work environments with unclear boundaries and roles, and job incompatibility relative to the women's current interests, skills, and aptitudes. An emergent theme mentioned relates to an inability to control anger and frustration at work.

Hostile Work Environments

The participants discussed work environments they considered hostile. Some women reported experiencing age discrimination, sexual harassment, and bullying. Louise reported experiencing both overt and "subtle" forms of chauvinism and age discrimination on the job. She recalled an incident in which her boss invited all the secretaries out to dinner and did not invite her because of her age and lack of education. Francis recalled a situation in which her boss told her that she couldn't work as quickly as others because of her weight. Molly reported being harassed on the job by male coworkers. She routinely encountered inappropriate behavior and language directed toward her on the job.

I was one of the only women that worked there, and um, that was very difficult, it was like a locker-room mentality . . . You, you know, they, they be talkin' about sex in front of me, and you know, like I was the token, they were very, um, chauvinistic.

Work environments with unclear boundaries and roles.

Women also reported difficulty in jobs that had unclear boundaries and roles. Christine worked as an administrative assistant for an eye doctor and reported that

"the professional boundary was gone" when her boss asked her "where she could find a good man." Jen worked as a radiological technician in a hospital and stated that she "never felt comfortable...no one would help me...they leave you, they throw you into the situation." Sandy worked as a community organizer at a local nonprofit organization and found that the organization lacked leadership, provided little structure, and offered little feedback.

Um, well, there just wasn't very much structure...we worked basically as a collective, there were other...volunteers that were all doing community organizing. And our relationship with our boss was sort of unclear. Again...it just wasn't very much structure, it was vague, the relationship structure was really...not clear, not organized.

Job incompatibility and poor fit.

The participants reported difficulty in jobs that were incompatible and a poor fit relative to their interests, aptitudes, and skills. They also found jobs that jeopardized their recovery to be poor fits. Christine is a highly educated woman who worked for many years as a psychotherapist. She described a difficult period during which she had just been released from hospitalization for depression, needed income, and took a cashier position in a hardware store. She reported difficulty in adjusting to the job because it was not compatible with her skills or interests.

Got out of the hospital, and just needed something for money and didn't feel like I was healthy enough to work as a therapist...I was working in a hardware store...First I was a cashier, and what would happen is guys would come up with a handful of nuts and bolts and nails and put 'em in front of me... I

wouldn't know what they were called, or much less what they cost, and I didn't know if they were playing a game with me. I couldn't figure it out.

Corrine described her internship working with male sex offenders and parolees. Corrine has a history of domestic abuse and panic attacks. She described this work experience as difficult because it was

kind of nerve-wracking, because they could be almost anybody, from sex offenders, to abusers, to anything, so sometimes that's a little, really awkward for me . . . Yeah, but it's the anxiety attacks . . . I like talkin' to ladies and things and bein' with the ladies, but sometimes bein' around mens, it kinda like, um, it's kinda hard to focus sometimes. Um, I know it's not the person that was the abuser, but it still, I don't know, you still be uncomfortable sometimes, at least I do, around a male, male, male peoples.

Carla has a significant substance abuse history and recalled her job as a bartender as a difficult work experience because she put herself at risk. She eventually relapsed and drank on the job.

I struggled in, uh, bartending . . . probably because of my, my alcoholism, um, you know, it just didn't play hand-in-hand. And when I did that I did the worst that I could in my life...I mean I wasn't a bad bartender, but I certainly wasn't there to serve the others alcohol, I was there for my own, you know.

Anger and Frustration

Participants reported situations in which they experienced difficulty managing their anger and frustration on the job. Julie reported having been fired from jobs in which she did not receive "enough support" and became "frustrated" and lost her

"temper." She described these situations as instances when her "posttraumatic goes into overload," negatively affecting her job functioning. Gail described becoming angry and/or "defiant" on the job. She also reported difficulty in navigating the culture and politics of the workplace. Gail described herself as "self-destructive" and having difficulty managing her frustrations on the job.

Research Question 2

What Are the Mental Health Counseling Experiences of Women Trauma Survivors
Who Are Returning to Work?

Table 2

Question 2: Mental Health Counseling Experiences

<p><i>Recurrent themes</i></p> <p>Supportive counseling</p> <p>Trauma counseling and recovery</p> <p><i>Emergent theme</i></p> <p>Preparation for return to work</p>
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Mental Health Counseling and Returning to Work

Study participants were asked about their experiences with mental health counseling in terms of preparing to return to work. They reported a range of helpful counseling experiences. Recurrent themes included participants' perceptions that supportive counseling and trauma counseling are helpful in returning to work. Emergent themes included mental health counseling that addressed preparation for

work, such as helping women with vocational planning, accessing vocational services, and improving work functioning and work behavior.

Supportive Counseling

Participants found their counselors' commitment to their recovery helpful. Several women reported that supportive counseling that provided encouragement and positive feedback was helpful to their vocational rehabilitation. Shelly described her long-term therapist's commitment to her progress and recovery. Medicaid no longer covered the cost of therapy, but her therapist arranged an affordable payment plan so she could continue therapy.

And she initially, she took Medicaid initially, um, and then when she wasn't able to do that we worked out a fee that was a lot lower than her regular fee, um, so I felt, you know she had a pretty strong commitment to my progress. Um, and, and that made it harder for me to sort of give up on myself, um, because here was someone who kept, you know, showing up, and cared about my welfare.

Christine reported that her counselor acknowledged her achievements and interests in music and writing and affirmed the possibility of her returning to work. Christine reported that her therapist "believed" in her "resilience" and her ability to continue to work on her recovery and pursue her career interests.

She always reminded me that we would be colleagues one day soon, and that she looked forward to that. She . . . always read my articles, 'cause I kept writing about psychotherapy, and about music . . . She gave me the feeling

like she just really believed in me, and my resilience. She encouraged the work that I did, the respite work and all of that.

Trauma Counseling and Recovery

Participants discussed their trauma recoveries in terms of improving their interpersonal skills and boundaries, challenging negative beliefs, and processing traumatic experiences. Two of the five women reported that participating in incest survivor and cognitive behavioral groups was helpful and improved their ability to set healthy boundaries in relationships. Candis reported difficulty in picking up social cues and understanding the dynamics and culture of the workplace. Candis returned to work after an extended leave related to domestic violence and found it helpful to discuss her "reactions to people" at work and whether her feelings were "valid." Sandy reported that her psychiatrist offered helpful insights related to her job functioning and establishing appropriate boundaries on the job. Her psychiatrist suggested that she was over-identifying with workers due to her abuse history as a "sex slave." Sandy found that her role and responsibilities as a union organizer became unclear and her performance on the job suffered. Sandy also stated that her psychiatrist believed that she "was exaggerating the amount of oppression that they were experiencing, because of my own abuse." Shelly reported that therapy helped her gain insight into her behavior and thought processes. She stated:

It helps me figure out, you know, why I behave the way I do, and why . . . I have the issues I have interacting with people . . . I need to do that . . . it would be very tempting to . . . just kind of stop in my tracks.

Participants also found that processing traumatic experiences was helpful to their recovery and vocational rehabilitation. Carla discussed her process of recovery as one that addressed a belief system shaped by trauma and addiction. She believed her therapist was helpful because it helped her address her negative belief system.

She basically, she puts a positive twist to everything, you know what I mean? When I find something negative, and you know she is able to help me see things in a positive way, I might not feel it or think it yet, but she's a, I can look at it that way, and I say, "Oh, I see, like the cup is not half empty, it's half full." You know, but when you've been so negative your whole entire life and everything has been based on anger and fear, insecurities, doubts . . . And that's the way that I've seen things for most of my life.

Corrine was burdened by symptoms and emotional responses associated with trauma. Corrine reported that she felt better talking about it in therapy and as a result developed a different perspective so she could move forward with her life. Corrine described her experience of her healing and trauma recovery:

And after a while, after I broke the ice, and I got comfortable with the person, all the trauma and all the stuff, I was able to talk about it. And the more I talked about it the better I felt...Even experiences with your childhood and things that you didn't realize that went on...I had blacked it out...I just didn't remember it, but as I had counseling with the mental health peoples...all of it came out. And it was like a relief, and like you felt like a new person...Because other than that if you don't get that out of you, and get it away from you, you still walkin' around with something goin' on inside of

you. It's like you got a heavy load and you don't really know why, your world is not the same, and um, after that came out it, it was wonderful. I mean, I had all this positive feeling that I've felt like a whole load had been lifted off of me . . . and I looked at life in a different perspective.

Preparation for Returning to Work

Participants reported that mental health counseling focused on preparation for returning to work was helpful. Participants believed that referral to services, addressing work functioning in terms of work attitudes and habits, setting goals, and planning and modeling were helpful in the context of returning to work. Christine spoke of her therapist's knowledge of community employment services, which facilitated a referral to MRC for vocational rehabilitation services. Christine stated that her therapist "filled out the paperwork for" her so that she could apply for vocational rehabilitation services. Christine also reported that her poor attendance had been problematic and her "biggest fear about going to work." Christine's therapist addressed her poor work attendance by contrasting it with her regular attendance at therapy sessions. Her therapist commented, "Well, you come here on time, you've never missed a time here, doesn't seem like you can't show up." As a result, Christine remembered that "I seem to get everywhere that I'm supposed to be . . . I remembered that I've done sessions while I had a killer headache." Julie has difficulty navigating social interactions on the job and wished a counselor could view her incidents at work firsthand to help her "strategize" and gain better insight so that she could "function" better on the job.

Learning how to set goals, prioritize, make adjustments, and take risks was important to some participants. Gail found mental health counseling helpful to keep her from "backsliding" and keep her focused on her "priorities" and "energies" related to her vocational rehabilitation. Charlene found mental health counseling helpful because it was goal-oriented and focused on current events, her strengths, and her career interests. She found this counseling approach different from past counseling experiences, which had more or less focused on pathology associated with a severe mental illness. Sandy described her therapist as a role model and a person who lives with a severe physical disability: paraplegia. Her therapist is wheelchair-bound and needs a personal assistant to help him function on the job. Sandy gained unique insight by observing her therapist's acceptance of his "dependence" on others for his basic needs and at the same time his "independence" and his achievement, competence, and initiative, which allow him to function adequately in a highly skilled and multifaceted job. Sandy believed that maintaining employment required being able to accept help from others while also being able to work independently.

He's dependent, and he's independent . . . that's my combination, or that's what I'm gonna need . . . I have the dependence, I need the independence . . . I need to remember that I have both . . . I was startin' to feel kind of bad about the dependence part . . . I can really have both.

Research Question 3

What Are the Vocational Rehabilitation Counseling Experiences of Women Trauma Survivors Who Are Returning to Work?

Table 3

*Question 3: Vocational Rehabilitation Counseling Experiences**Recurrent themes*

Counseling and guidance

Vocational strategies, skills, and assessments

Career decision making and planning

Interpersonal skills

Assessment

Emergent theme

Supported job search

The researcher asked study participants about their experiences with vocational rehabilitation counseling in terms of how it helped them in returning to work. Recurrent themes include the benefits of counseling and guidance along with vocational strategies, skills, and assessments. Several of the women believed their relationships with their VR counselors to be critical to successful vocational rehabilitation. One interesting emergent theme identified was that of a supported job search that involved regular meetings with a job placement specialist.

Counseling and Guidance

Study participants reported that the counseling and guidance they received from their VR counselors was helpful to their vocational rehabilitation and return to work. Corrine, as part of her vocational rehabilitation plan, was enrolled in a college-level certificate training program. Corrine reported that her VR counselor's support, guidance, and encouragement increased her self-confidence and made her feel good about herself.

The worker I have here, she's very good . . . she try and keep me on track with everything, and she's always focused on me, and . . . she givin' me good praise...so I feel good. I tell her I got "A" for my classes, I got "A's," two "A's" and a "B" . . . she was really happy for me . . . she sounded like she . . . is genuine about it, and so I like that. . . . When someone say you did a great job, that makes me feel really good. And I guess everybody like to hear encouragement, being encouraged to do this.

Julie had a history of difficulty in navigating work culture, roles, responsibilities, and interpersonal relationships on the job. These difficulties impacted her ability to work cooperatively and communicate with coworkers and supervisors when she was working as an educational aide at a local grammar school. As a result, she was fired from the position. Julie believed her VR counselor helped her cope with feelings related to her negative work experience and termination. In addition, she believed her counselor helped her make good career decisions. Julie described her counselor as direct, honest, non-judgmental, and practical.

R has been helpful because I can tell her what's going on and she's very non-judgmental. She's a very pragmatic person . . . so, you know, I told her I'm writing that rebuttal letter, she's like, "Why?" I said, "I'm doin' it for me." I'm hopin' somebody will have the curiosity to open the envelope, but I'm doing it for me so I can let go of it. Um, she doesn't mince any words, she's extremely honest. It wasn't like, "Well, gee, you could just go and try it." She's just extremely direct, and I needed to hear that, as painful as it was, 'cause I put a lot of energy into that job for 9 months, [but] it was the wrong job.

Vocational Strategies, Skills, and Assessments

Participants identified a range of vocational strategies, skills, and assessments that were helpful to their return to work. They included (1) career decision making and planning; (2) interpersonal skills; (3) assessments; and (4) a supported job search.

Career Decision Making and Planning

Participants reported that their vocational rehabilitation counselors helped them with career decisions, planning, and setting realistic and achievable vocational goals. Christine believes that vocational counseling kept her from becoming "stuck" and moved her "closer" to securing employment. Candis was able to process her feelings, which allowed her to make good decisions with her VR counselor about returning to the nursing profession and/or school. Candis reported that her VR counselor helped her to become more realistic "about a lot of things" and "in terms of money and age and cost."

Interpersonal Skills

Participants believed that building interpersonal skills was important to their return to work. Louise reported that the soft skills training to which her VR counselor referred her was extremely helpful in preparing her for the return to work. Louise also found that the feedback she received from the soft skills training was positive and "complimentary."

Assessment

Participants believed that assessment of their ability, aptitudes, work skills, and interests was helpful to career decision making and preparation for the return to work. Carla reported that her VR counselor had arranged a neuropsychological evaluation to help determine whether she had a learning disability that would affect her learning and school performance. Shelly found that the process of résumé writing allowed her to "validate" and assess her skills, work experiences, and education. By engaging in the résumé-writing process, Shelly was able to process her feelings and objectively view her work history in the context of her age, disability, and recovery.

I had started writing a resume again, after, you know, not even wanting to look at that in such a long time. So I had help with that. It's, you know, I mean, in a way it should be, um, you know, sort of an exciting thing to do, because you get to . . . you get to validate the experience that you do bring . . . you know, in a way it was a good exercise, but it's also . . . it can be humiliating, because you look at... you know, with my age, I just look at how old I am, and look at . . . periods of my life when . . . I couldn't work, I

couldn't volunteer, I couldn't be in school, I couldn't do any of them. . . .

You know, it brings up . . . all of those feelings.

Supported Job Search

One participant reported that a supported job search was helpful to her return to work. Sandy's VR counselor referred her to a community job placement program that assists people with disabilities with employment. Sandy believed regular meetings with a job placement specialist were helpful and provided necessary support and structure for a successful job search. "She set me up to go to a placement service, where they're gonna . . . help me with my résumé, and make sure I look up jobs, make sure I make the calls . . . to apply for jobs."

Research Question 4

What Factors Do Women Trauma Survivors Perceive as Facilitators of and Barriers to Employment?

Table 4

Question 4: Factors Women Perceive as Facilitators of and Barriers to Employment

Facilitators	Barriers
<p><i>Recurrent themes</i></p> <p>Good relationship with counselor</p> <p>Meaningful work</p> <p>Rehabilitation and trauma counseling</p> <p>Family support and finding supportive people</p> <p>Accessing public programs and community resources</p> <p><i>Emergent themes</i></p> <p>Vocational planning and decision making</p> <p>Job satisfaction</p> <p>Community activism</p>	<p><i>Recurrent themes</i></p> <p>Health and psychological factors</p> <p>Addiction/substance abuse</p> <p>Social isolation and lack of support</p> <p><i>Emergent themes</i></p> <p>Incarceration</p> <p>Unclear work roles and boundaries on the job</p> <p>Employers' lack of awareness of PTSD and its effects on work functioning</p> <p>Securing basic needs (e.g., Social Security, housing, food, benefits)</p>

Study participants reflected on what had been helpful in returning to work and what had gotten in the way of returning to work. Participants identified a range of factors they perceived as facilitators of and barriers to employment.

Facilitators to Employment

Recurrent themes that study participants considered helpful were: (1) having a good relationship with their counselor; (2) meaningful work; (3) rehabilitation and trauma counseling; (4) finding supportive people; (5) accessing public programs and community resources; and (6) assessment of skills and aptitudes. Some emergent themes that participants considered helpful were planning and decision making, and community activism.

Good Relationship with Counselor

Some participants reported that the relationship they have with their VR counselor was helpful to their vocational rehabilitation and return to work. The connection participants developed with their VR counselors, along with the guidance and feedback participants received from their VR counselors, was an important factor in their vocational rehabilitation. One woman said the "close connection" she had developed with her counselor was helpful to her job search. Another woman stated that she had established a "good rapport" with her VR counselor so that she could openly discuss medical issues and "go at her own pace."

Meaningful Work

Christine believed that doing meaningful work helping others reduced her isolation and connected her to the larger community. She had been unable to hold steady work as a result of her severe symptoms associated with mental illness, but

was able to volunteer at local non-profit organizations helping children and families. Volunteer work was important to her because she believed that "it may not be the money" and it is important to be "doing something worthwhile" and "giving something to the world." Molly stated that working as a residential assistant for developmentally challenged adults "makes me feel good about myself, that I'm helpin' people . . ." She further stated that she gained "self-satisfaction" by doing "somethin' to help people, and be productive in society." Mary spoke about her decision to become a substance abuse counselor and her motivation and interest in her own recovery through helping people with their recovery.

And I don't really wanna make a difference, but I'd like to be there to see the difference, in how people change. I've had to change, over the past few years. I'd like to give back what was so freely given to me.

Rehabilitation and Trauma Counseling

Some participants believed that participation in Alcoholics Anonymous and individual and group therapy reduced PTSD symptoms. These women were struggling with mental health issues and substance abuse, including symptoms of depression and anxiety. Shelly believed that her health and recovery were the cornerstones of her successful vocational rehabilitation. She struggled with anorexia and stated that "the first critical thing" was to "find the right therapist to work with." Corrine reported that the staff and groups at her outpatient recovery program for trauma and substance abuse were helpful and gave her "courage," "high praise," and "encouragement" to return to school. Carla reported that AA and the structure of a sober house have been critical to her sobriety and recovery and helpful to her ability

to plan for her future. She names her low self-esteem and lack of motivation as key barriers to pursuing career interests and returning to school.

What's been very helpful [is] workin' on the . . . and Alcoholics Anonymous is the program. I live in a sober house, um, and that's been very helpful, I need structure right now, because I've been so out of sorts, you know, like I said I was homeless out here on the streets of Boston. Fat chance that I'm gonna go back to school being, living on the church stairs, that I'm even gonna find the motivation, 'cause my low self-esteem would be so much. You know, who's gonna wake up in the morning on the church stairs, say, "Well, I'm goin' to college today," 'cause it's just not gonna happen, you know, something has to change within . . . I have to seek mental help, I have to seek, you know, spiritual help, and physical help. It's a three, it's a three thing.

Finding Supportive People

Some participants reported that having supportive people in their lives was helpful for trauma recovery and vocational rehabilitation. Anna stated that she wanted to be "around compassionate people," people that understand and "have an awareness of PTSD." Another woman said that her children were an important source of support and critical to her successful recovery and rehabilitation. A woman with a history of incarceration, substance abuse, and prostitution found support from what she considered a most unlikely person: a nun.

Accessing Public Programs and Community Resources

One woman, whose therapist referred her to the public VR program, found it helpful to her vocational rehabilitation and eventual return to work. Another woman

was referred to a community vocational program for people with disabilities by her vocational rehabilitation counselor. She tends to isolate herself and admits to having difficulty following through with appointments.

Yeah, for me it's really about people reaching out, and not letting me get isolated. So I called and said, "Oh, you know, I'm very interested, and what's the next step?" And so we made an appointment. If they hadn't called me, I, you know, I might never have called them.

Assessment of skills and aptitudes.

Participants reported that vocational tests were helpful to their career development and vocational planning. Louise is skilled in factory work, but over the years manufacturing jobs have disappeared due to plant closings and relocations. She found vocational testing helpful because it identified areas she "was very good at." Gail believed that taking a vocational aptitude test would be helpful in terms of career planning.

To take the aptitude test, to confirm, in terms of what I could do, and to be aware of (what) the job market projections were, and to really be more strategic about planning . . .

Some emergent themes included participants' vocational decisions and planning, job satisfaction, and community activism. One woman believed that prioritizing family responsibilities in order to focus her energies was helpful to her vocational rehabilitation. She believed that for her to engage fully in vocational rehabilitation she had to "rearrange" family responsibilities so that she became the "center" of her "own world." Another woman felt she needed to "cover the bases" as

far as securing safe housing and health care before returning to work. Job satisfaction also emerged as an important factor. One woman reported losing jobs due to interpersonal conflicts with coworkers and supervisors. She believed she needed a work environment with structure, consistency, and predictability to be successful. Another woman believed that her age, maturity, and experience were helpful. Earlier in her career she reported being overly concerned about being "liked by her coworkers;" as a woman now in her forties, she is not as concerned about "being liked" and is more comfortable navigating social interactions on the job.

Barriers to Employment

Participants reported several factors as barriers to employment. Recurrent themes included health, psychological, and substance abuse issues; social isolation; and lack of support. Emergent themes included incarceration, PTSD and its effects on work functioning, and securing basic needs (for example, housing, food, and benefits).

Health, Psychological, and Substance Abuse Issues

Many participants reported a range and various combinations of health problems and mental health issues affecting their vocational rehabilitation and return to work. Reported health problems included severe migraines, breast cancer, fibromyalgia, injuries, and chronic pain. Some participants believed their health and psychological issues significantly interfered with their ability to participate in training or return to work. Francis spoke of her difficulties in going to school while trying to manage her weight, diabetes, and depression.

I'm a diabetic, so my diabetes gets in it. Wanting to take the medication that I need to take, all the time. For school, the medication makes me sick to the stomach. If I [have] problems, [I have] to ask to be let out of the classroom for the moment to go to the bathroom, or to take the medication.

Francis's story is representative of many of the women in the study who struggle with both health and psychological issues. Another woman worked for approximately 15 years as a radiology technician. She sustained a repetitive strain injury on the job and underwent painful surgery and a long recovery. At the time of the interview, she was not working and was living in a shelter, receiving substance abuse treatment, and experiencing complications related to the injury and surgery. Shelly, who is a trauma and cancer survivor, receives and has received in the past intensive and long-term treatment for breast cancer, depression, and anorexia. She described her difficulties working as a community activist while undergoing radiation.

Breast cancer really set me back in a lot of way(s). You know, I developed a lot of skin problems, going through the radiation, and it's another reason that I'm very self-conscious; it makes it harder for me to do things in a public way, and the kind of work that I'm interested in, [by] its very nature it's public. It's speaking in public, going to meetings, lobbying. You have to interact with a lot of people.

Some participants reported that substance abuse and subsequent addiction were significant barriers to successful vocational rehabilitation and the return to work. Carla spoke about her substance abuse and the patterns that led to her relapse.

I end up fallin' short again, and I end up relapsing on drugs and alcohol, or I get into an unhealthy relationship, which eventually ties me right back to what I always do. So, it's a pattern with me. If you always do what you always did you always get what you always got, and that, that's the way it plays for me. So I have to change everything and . . . become aware of the triggers or the patterns.

Social Isolation and Lack of Support

Some participants reported social isolation, lack of support, disconnection, and estrangement from family as factors that got in the way returning to work. One woman believes her estrangement from family has made career decision making and planning more difficult because of doing it "alone" and without an "audience." Anna believes that her feelings of "powerlessness," "losing control," and "not connecting with other individuals" can become "overwhelming."

It's that sensation of powerlessness. It's a sensation of . . . losing control; it's a sensation of people not understanding and you not connecting with other individuals, and it can become overwhelming. So I think that is a definite obstacle.

Emergent themes as to what got in the way of returning to work were incarceration, unclear work roles and poor boundaries on the job, employers' lack of awareness of PTSD, disclosure of disability, and obtaining and maintaining basic needs such as housing and Social Security benefits. One woman was "arrested" and "thrown into . . . prison" for 60 days for non-payment of child support. Before her stay in prison, she had been embroiled in a long and bitter legal struggle with her ex-

husband and abuser for custody of her children. She has had to make many court appearances, making it difficult to keep her jobs and support her children. Other participants struggled with establishing and maintaining appropriate boundaries, work roles, and relationships on the job. Candis described her difficulty with staying within her work roles and responsibilities as a clerical assistant in a hospital. She believes that she is overly "vigilant" and "cautious" on the job, which has affected her work functioning. She described a situation at work in which she was worried about whether the patient she was assisting was "safe," and as a result left her work responsibilities to take the patient to the correct department within the hospital.

I actually ended up taking a patient and wheeling them all the way back, um, to where they were supposed to go. I mean, I went above and beyond probably what I should have, but, um, just to insure that that person was safe. And, um...and you know, I felt comfortable, I mean it was, to me, I'm the kind of person, you know, somebody asked me to take somebody someplace, I do it with a hundred percent, 'cause I just, I don't want to not, see somebody not safe, so, but um, that, that's just caution, so um, and I think maybe that took a little, took away from my clerical part of things, but that was okay, I kind of caught up on everything.

Another woman spoke about her experience with an employer who was aware of her disability. She had been referred by a counselor from a public vocational rehabilitation program. She described her difficulty in dealing with the stigma associated with mental illness and her discomfort with being treated differently on the job.

Again, I went in there, through Mass. Rehab., which I, which I kinda wish I, I didn't, because everybody knew I came from Mass. Rehab., in the company . . . and like they're fishin' around, seein' if I'm a convict or somethin', so finally I came out and told them. . . . I was kinda treated a little different. . . . I think people do have a preconceived notion of someone who has a mental illness. (Molly)

One woman was concerned that if she returned to work her Social Security benefits, subsidized housing, and health care benefits might be terminated. She believes the "structure of Social Security" is a deterrent to the return to work.

What's gotten in the way are things like what I've mentioned, um, with um, you know, my stress levels are housing, um, and then um, um . . . the structure of the Social Security, um, is a hindrance the way they have it. It's kind of scary, frightening. (Anna)

Additional Interview Questions

The researcher included the following three questions in the interview:

What are some factors you have had to consider in making decisions related to your return to work?

What would you tell professionals about what might be helpful to the return to work?

What would you say to other women about what was most helpful to your vocational rehabilitation?

*What Are Some Factors You Have Had to Consider in Making Decisions Related to
Your Return to Work?*

Table 5

Factors Considered in Making Decisions Related to Return to Work

<p><i>Recurrent Themes</i></p> <p>Health concerns</p> <p>Psychological challenges</p> <p><i>Emergent Themes</i></p> <p>Housing</p> <p>Education and training</p> <p>Family</p> <p>Self-esteem and connection</p> <p>Personal safety</p> <p>Transportation</p> <p>Legal issues</p> <p>Age</p>
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Women in the study were asked to identify and describe factors they considered when making decisions related to returning to work. Participants reported a range of factors. Health concerns and psychological challenges were recurrent themes among participants. Other emergent themes generated from what participants

reported included housing, education and training, family, self-esteem and connection, personal safety, legal issues, and age.

Health Concerns

Participants reported health issues as being a key factor that affected decisions related to work. Health issues reported included diabetes, hypothyroidism, hysterectomy, arthritis, fibromyalgia, learning disabilities, cancer, and Hepatitis C. Participants reported that their health had directly impacted their performance on the job and their participation in training programs. Some participants reported that their health issues needed intensive treatment before they could consider going back to work. Others reported fatigue, decreased mobility, and reduced stamina related to medical problems. For example, Corrine reported having arthritis and recent surgery on her neck. As a result, she was unable to stand for extended periods and had difficulty using public transportation going to and from work. Gail reported being concerned about caring for long-standing health issues before she returned to work.

Well, I have to have a hysterectomy . . . All right, so, you know, getting things like that done. . . . Uh, eye care, dental care, various things that I had been putting off that I needed to now bring to the forefront and get done, as well as the other things preparing myself to get, uh, back into the workplace.

Psychological Challenges

Some participants reported adjustment to psychological problems as a key factor related to making decisions about work. Some of the reported psychological problems included depression, grief, suicidal ideation, and PTSD. Christine described the "revolving door syndrome" in which she had "periods where I was, um, in and out

of the hospital; a lot of depression, like a five-year-solid period." Anna describes PTSD as a debilitating and hidden disability.

There is the lack of understanding of what posttraumatic stress syndrome is and does to an individual to the point where they can't, um, function on a consistent basis. . . . So it's, I think that's part of the problem. Because people can't see it, can't touch it, can't feel it, they think it might not be real.

Housing

Participants emphasized safe housing as a significant factor related to their decision making and return to work. Some participants reported that they were homeless at the time of the interview. Anna considered going back to school and was concerned about whether she would have a safe and quiet place to study.

Well, a major factor would be housing . . . without, you know, a door to close and be able to sit down quietly and focus on your books, that could be a major challenge, and it is.

Candis also spoke about the importance of safe housing. At the time of the interview, she had recently left an abusive relationship and returned to work. "I'm a single woman, um, and I've been able to um, secure housing and safely live in a neighborhood that's relatively, uh, supportive, and it's, it's a very good neighborhood."

Education and Training

Participants reported that education and training were significant factors related to the decision to return to work. The participants believed that postsecondary training and a college degree would afford them a better job. Shelly was a 50-year-old

cancer survivor who struggled with chronic depression. Shelly was able to obtain a college degree but reported many difficulties in paying college tuition and managing her chronic medical issues. Francis believed that her lack of education and training limited her to lower-paying entry-level jobs. "Education was a factor, so I always had to take entry-level jobs."

Family

Participants reported family as being a key factor when making decisions about returning to work. Participants who were primary caretakers reported concerns about the well-being of their family members. Gail reported concerns about prioritizing and balancing her energies between returning to work and caring for her elderly parents. For Christine, a key consideration for her return to work was the care and well-being of her 23-year-old son, who had been diagnosed with a learning disability and had problems with substance abuse. Corrine reported that her children were a motivation and instrumental to her vocational rehabilitation and stated, "The wants and the needs of my children, to, to want to have something better for them, always pushed me forward."

Self-Esteem and Connection

Participants reported that important motivators related to decisions about returning to work or engaging in education or training were to feel productive, stay connected to others, and maintain a sense of purpose in their lives. Sandy's statement best exemplified some participants' needs for connection, purpose, and structure through work.

Doing something productive, and not just, and having some structure, and some people-contact, and getting out of the house. That's, that's really the second reason I wanna do it. Yeah, yeah, just being around people, having more of a purp—sense of purpose.

Personal Safety

Participants reported that their personal safety was a factor in making decisions about returning to work. Charlene was concerned that she might be unable to move to another location and feared that her ex-husband would obtain her new address. Corrine avoided places she knew her abuser frequented.

That was my biggest fear, running into them . . . if it's places that I think they used to be hanging out or somethin' I try to avoid those places, so I don't go there. And sometime it's hard, because you gotta take a longer way, or a longer route, but it's, it's comfortable for me, because I feel better.

Transportation

Participants reported that transportation was a significant factor when making decisions about returning to work. Christine was unable to drive on highways and described herself as "highway-phobic." Her inability to drive using highways kept her from considering many jobs. Candis was on a fixed income and worked part-time, and considered transportation costs for getting to and from work in her budget. "In terms of transportation, um, I'm, I want every little penny, and I, I do take public transportation, so that has been, um, something that I've been able to work into my budget."

Legal Issues

Participants reported that legal issues were considerations in making decisions about returning to work. Jen stated that she had lost a radiology tech position because she was unable to take time off to appear in court. Carla's criminal record impacted her ability to return to her profession as a hairdresser.

In fact, the beauty industry is one of them that asks the question "Have you been convicted of a felony?" and if you have they need to have a notarized letter, um, stating what your crime was, and if you're on probation or parole, a letter of good standing.

Age

Mary was enrolled in a training program to become a substance abuse counselor. She was concerned about her age and lack of experience and feared that competition would make it difficult to secure employment in her field. "My age, I'm 47 in two weeks . . . the competition out there, the field I'm goin' in, I'm like no experience whatsoever..."

*What Would You Tell Professionals about What Might Be Helpful to the Return to
Work?*

Table 6

Comments to Professionals about What Is Helpful in the Return to Work

<p><i>Recurrent Themes</i></p> <p>Approach and engage women with empathy, understanding, compassion, encouragement, and respect.</p> <p>Sensitivity and awareness about the impact of PTSD and Domestic Violence on work</p> <p>Access community resources and understand the importance of women's securing basic needs (e.g., Social Security benefits, housing, health care).</p> <p>Help to access and/or develop groups, skills training, and interventions for women survivors returning to work</p> <p><i>Emergent Themes</i></p> <p>Awareness of gender bias and age discrimination experienced on the job.</p>

Participants in the study were asked to reflect on what they would tell professionals regarding what was helpful to their return to work. Recurrent themes generated from participants' responses were: (1) to approach and engage women with

empathy, understanding, compassion, encouragement, and respect; (2) sensitivity and awareness about the impact of PTSD and Domestic Violence on work; (3) to help women access community resources and understand the importance of women's securing basic needs (for example, housing and health care), as well as increase knowledge of disability benefits and the impact of those benefits on decisions about returning to work; and (4) to help access and/or develop groups, skills training, and interventions for women survivors returning to work. An emergent theme generated from one woman's response was the need for professionals to increase their awareness of gender bias and age discrimination experienced on the job.

Empathy, Compassion, Encouragement, Respect, and Understanding

Many women in the study wanted helping professionals to show empathy, compassion, and respect within the context of their recovery and vocational rehabilitation. Participants also believed that helping professionals needed to increase their awareness of the impact of interpersonal violence and PTSD symptoms on work functioning. This increased awareness may help professionals develop compassionate and respectful relationships with women survivors. One woman believed it would be helpful if professionals were

. . . reaching out, spending time, being compassionate . . . trying to really understand what the person needs (are). It's like I can come across as not needing that much, but I actually do. So that's, that seems important to me.

(Sandy)

Another woman discussed the importance of professionals' understanding and respecting women's needs and fears of "trying something new." She emphasized the

importance for professionals of understanding both external factors (for example, family, safe housing, health care, food, and transportation) and internal factors (for example, lack of self-confidence, low self-esteem, poor self-image) that provoke fear, keep women from taking risks, and serve as barriers to women's recovery and employment.

You know, once you've made some progress in your life you're very protective of that . . . you're very cautious, um, so it's sort of keeping in mind "Okay, here are the supports that, that somebody needs, those basic things that have to be in place . . . then you can look at sort of some of the internal stuff, or the emotional stuff, um, that maybe makes somebody . . . fearful about trying something new . . . you can't look at one and ignore the other. . . . I feel respected when somebody is able to look at . . . all of those things going on with me. 'Cause that's, that's how my life really is. (Shelly)

Other participants wanted to tell professionals that they desired help in setting achievable and manageable goals. Corrine, an African American mother of nine, trauma survivor, and recovering addict, wanted to tell professionals to permit women survivors to "do it in their own time, don't push it, don't rush it, and it goes better." Another woman wanted to tell professionals to "let women take baby steps" so as to "not break their spirit." Julie, a single woman who has a sporadic work history related to interpersonal conflicts with coworkers and supervisors, would like to tell professionals "to encourage people to do more than they think they can do . . ."

Increase Sensitivity and Awareness about the Impact of PTSD and Domestic Violence on Work

A significant number of participants reported that they would like professionals to increase their awareness of the debilitating effects of PTSD and domestic violence in terms of their vocational rehabilitation and return to work. Some participants wanted professionals to become more aware of the impact on women of and challenges related to PTSD and domestic violence. Women reported some challenges they faced, such as shame, problems with independence, startle responses, poor interpersonal skills, emotional dysregulation, and anger. One woman discussed her startle responses as directly related to her abuse and worried that it can happen in a "workplace," would never "go away," and "freaks people out." Another woman stated that it is critical for helping professionals to become aware and understand women survivors' "internal and external obstacles." She described external obstacles including women's struggles to cover basic needs such as food, housing, and transportation. Internal obstacles include psychological and emotional responses related to trauma and substance abuse.

Understanding the Importance of Accessing Community Resources and Securing Basic Needs

Participants reported that professionals were helpful in finding community resources and programs for housing, transportation, employment, and training. One woman wanted counselors and other helping professionals to inform women and "let them know what the resources are that are available." Anna, a single Latina woman who receives SSDI benefits, believed that safe and affordable housing is critical,

keeping people from "falling through the cracks," and key to training and successful return to work.

The housing . . . I mean, if you don't have that base, how are you supposed to function? . . . How are you supposed to get the other stuff done? . . . Then what's the sense of even trying to go to school? Where exactly are you gonna close the door and study?

Another woman spoke to the importance of safe and affordable housing and adequate health care.

So if someone is very worried about the stability of their housing, that's gonna be their preoccupation . . . you can't think about anything else. So . . . it's keeping those things in mind, you know, stable, affordable housing, and access to, to health care, and just all of those basic supports, and particularly for someone, I think, with a trauma history. (Shelly)

Groups, Skills Training, and Interventions for Returning to Work

Some participants reported wanting groups and training for women to help them set goals, develop healthy relationships, learn negotiating skills, and develop interpersonal boundaries. Jen, a homeless mother of two teenage daughters with a history of substance abuse, said she would like help with "goal setting" and to improve her personal boundaries. She would like to avoid being "easily dragged into takin' care of everybody else, and you don't take care of yourself." Another woman who has a long history of difficulty keeping employment due to her anger believes that groups for "people with long-term posttraumatic (stress) who are trying to stay in the workforce" would be helpful. Another woman who also struggles with anger and

low frustration tolerance said that groups that improved women's "negotiating skills" would be helpful.

Awareness of Age Discrimination and Gender Bias

An emergent theme generated from participants' responses was awareness of age and gender. Two participants reported that they believed their age to be a factor in returning to work. Gail is a 54-year-old woman who has held many high-level positions. She struggles to find work environments that are compatible with and related to her peer group, style, and abilities. She reported that age differences between herself and her supervisors and coworkers made it more difficult to communicate and work cooperatively. Louise recalled a painful work experience where she believed she was mistreated and excluded based on her age. At the time, she was in her 30s and working as a receptionist in a small family business. She was also married and had three young children. She was consistently excluded from out-of-office events and did not receive the pay or bonuses the younger female employees received. She wants professionals to be aware that older women can and do face age discrimination in the workforce.

But employers . . . I don't know whether I'm bein', um, a prejudice on my part, but . . . they go for the . . . pretty, young girls, and they don't realize that they have such qualities . . . in older people . . . You know, I, I've learned if you don't like it, leave. . . . I mean, I did, did five jobs compared to that receptionist, and I know she got more money than me. (Phyliss)

*What Would You Say to Other Women about What Was Most Helpful to Your
Vocational Rehabilitation?*

Table 7

*Comments to Other Women about What Was Most Helpful to Vocational
Rehabilitation*

Recurrent Themes

Self-advocacy: Putting yourself first because you matter

Pursue your interests and build your skills

Access community resources and organizations

Develop a support system

Make a commitment to recovery and rehabilitation

Emergent Themes

Get support with job search

Compatible work environment

Have awareness of age and gender when returning to work

Awareness of the risks and consequences associated with
leaving an abuser

What Women Would Tell Other Women

Participants also reflected on what they wanted to tell other women as to what was most helpful to their vocational rehabilitation. Recurrent themes generated from

participants' responses were that women should advocate for themselves and that they should pursue career interests and build skills. Other common themes generated were that women should access community resources and organizations, develop support systems, and commit to rehabilitation and recovery. Some emergent themes were that women should seek assistance and support with job search, find compatible work environments, have an awareness of age and gender discrimination when returning to work, and understand the risks and consequences associated with leaving an abuser.

Self-Advocacy: Putting Yourself First Because You Matter

Many women in the study believed that self-advocacy, that is, taking care of themselves by asking for what they need, was critical to recovery and vocational rehabilitation. Some participants would tell women that "they matter, put themselves first, get your voice, be heard, and don't quit." One participant believed it was important for women to learn how to ask for help.

And I just, see, I'm learning now to ask for help. I'm learning to say, you know, "What about me?" You know? So that's what I'm learning. . . . I'm learning to do that. (Jen)

Another participant wanted to tell women to advocate strongly for themselves and ask for help to access resources.

"Um, I need this, this and the other thing, can you help me figure out how to get it?" Um, and y-you just, you can't take no for, for an answer. A lot of times people want to tell me no by virtue of the fact that I'm a woman and that I'm older . . . pick your battles and help someone help you fight your battles. .

. . I think it's very hard to women to request things, I think it's hard for them to demand things when they have to demand them. (Julie)

Pursue Your Interests and Build Your Skills

Some participants believed that it was important for women to identify career interests and pursue education and training. Study participants also thought that women should build their work and interpersonal skills. One woman believed that education and training would increase her earning potential and job satisfaction. Another woman stated, "Find something that you want to do, not something you have to do" (Mary). One woman participated in a women's group that focused on conflict resolution, interpersonal skills, and emotional regulation.

A group . . . we went like seven times, and it was like the best. 'Cause every subject was like, um, like, um, how do you take criticism . . . what you deal with when someone, like, criticizes you, how do you react, so we role-played that, you know, repeat what someone says, and how do you disagree with somebody without, you know, makin' them mad, stuff like that, you know. And um, it was like really, really good, you know, it was just . . . 'cause you got in touch with how you are. (Jen)

Access Community Resources and Organizations

Some women found it important to tell others to access community resources to cover basic needs such as housing, food, counseling, health care, benefits and employment, and training. One woman stated:

You have to take care of yourself, and that means knowing how to do things like get the food stamps, get the decent housing, um, get the decent support, you can't just be your only support. (Julie)

Another woman suggested:

And, um, I think reaching out to, um, any kind of multi-service—any kind of like center that helps you with um job finding, helps you with counseling, 'cause all those places have, um . . . (Jen)

Develop a Support System

Some participants believed it was important to develop a support system. Julie reflected on her experience of being her "own support system," and noted that working in isolation was difficult and typical of people with PTSD. Another woman believed that support doesn't just come from "professional people" but "from the person next to you that's goin' through the same thing, a similar situation" (Mary). Another woman reflected on her experience of people having "helped at critical moments . . . they've, um, they've been there for me" (Shelly).

Make a Commitment to Recovery and Rehabilitation

Some participants emphasized the importance of women making a strong commitment to their recovery and rehabilitation. One participant wanted to tell women that "there needs to be a decision to be rehabilitated" and to "do it decisively." Carla, a recovering addict, said that successful rehabilitation begins with a commitment to sobriety.

You know, it's what I do with what I know today, and I don't want to get high today, and that's, that's a miracle, that's God's grace within me today, and I

believe that because left to my own devices I'd be getting high. So, you know, I ask for help every day with that, that desire not to be there and for me just to face my life as I should.

Corrine wanted to tell women to seek good treatment by working with professionals that you "like" and are "comfortable with," and then "stay[ing] with them." She offered the following reason for her advice:

Because when you jump around, you gotta start all over again, because that person don't know anything, then you gotta relive all that all over again, but if you stick with the same person until you feel really good, that helps out.

Get Support with the Job Search

One participant believed that women should get support while on the job and receive assistance with job search activities (for example, résumé writing and interview skills).

Compatible Work Environment

One participant recognized that it may be important for women to work in an environment that fosters a sense of camaraderie and attracts people who share similar values and interests.

Have Awareness of Age and Gender When Returning to Work

One woman gave advice as an "older woman" returning to the workforce:

Okay, you don't let anybody stop you from . . . especially if you're an older woman . . . Be realistic, if I had to go in on a job interview, my hair isn't dyed right now, but if I had to go in on a job interview, believe me, I'd like to go to CVS, get a box of hair dye, dye my hair, because if you go in with your hair

un-dyed, the response is very different than if you go in with it dyed. Even if they know you're in your fifties. . . . The response is different, it's sad, but it's there. (Julie)

Awareness of the Risks and Consequences Associated with Leaving an Abuser

One participant wanted to tell women her experiences associated with leaving her abuser. She poignantly described the negative consequences and risks of leaving and indicated that staying in an abusive relationship may outweigh the cost of leaving.

They're gonna lose their children, they're gonna lose their possessions, they may lose their mother, because the thing is when you report abuse the abuser wants silence, and when he asks other people to accept his side of the story it means they don't have to do anything. When the abused person asks people to take their side she's asking them to do something. So it's in the entire town, or churches, or whatever is the comfort zone to believe the abuser didn't do anything. She's gonna lose everything . . . And the social service people are not going to catch her. Some women do get caught nicely, but she can't depend on that, and mine's to an extreme, I didn't get caught at all. That sometimes I would tell people to stay. You know once you walk out you can't go back, but I would really tell some women to stay, even though they're in a horrible situation.

Researcher's Impressions and Participants' Reactions

Generally, participants seemed comfortable, open, and in some instances eager to discuss and reflect on their experiences. I believe my years of counseling and interviewing experience helped facilitate a comforting tone and create a safe space so participants felt more at ease discussing their experiences. I was cognizant of my dual roles as a researcher and a vocational rehabilitation counselor working for the Massachusetts Rehabilitation Commission. I wondered how these roles might influence the women's openness in discussing their vocational rehabilitation experiences, as all participants were active clients at MRC receiving vocational rehabilitation services.

The length and depth of the interview varied among participants. Some women spoke at length and were comfortable talking about their work and trauma histories. Others offered less detail and were more concrete in responding to and answering interview questions.

For many women, talking about their work experiences provoked a range of emotional responses. Some women became tearful during the interview when recalling difficult and painful events. Some women were anecdotal and matter-of-fact and used humor to describe and reflect on their experiences. At times, I found it helpful to redirect, repeat, or reframe the interview questions, particularly for participants who needed more structure or encouragement. Overall, the women seemed interested and engaged in talking about their decision making and work experiences, as well as what was helpful to returning to work.

From my observation, it seemed that the women were at different stages relative to their vocational rehabilitation and recovery. One woman reported recently leaving an abusive relationship. At different points during the interview, she asked me to stop the tape because she became overwhelmed and needed to gather herself to continue. She eventually completed the interview and told me that she was glad she had finished. Another woman, who experienced difficulty focusing and managing her emotions during the interview, reported that she had recently left an abusive marriage. She was homeless and living in a shelter. She also disclosed having a history of hospitalizations for PTSD, substance abuse, and somatization disorder.

Other participants seemed further along in recovery. These women appeared to have stable and safe housing, were receiving good treatment for PTSD, and possessed good support systems and connections to the community. These women seemed to have taken substantial steps toward their vocational rehabilitation and return to work. One woman reported having a history of domestic violence and described her successful rehabilitation in terms of getting good counseling for anxiety, depression, and substance abuse. At the time of the interview, she reported that she was clean and sober, experienced fewer panic attacks, and was enrolled in a training program at a local college. She also reported receiving encouragement and support from her family.

Regardless of where women were in their recovery, all struggled to navigate and access the many systems and institutions needed to meet their basic needs (for example, housing, health care, food, transportation, and employment). Participants discussed how systems and institutions affected their return to work.

The data reflects the complex and challenging nature of the lives of these women who are trying to return to work after experiencing trauma. Feminist and ecological models provided contextual frameworks by which to examine the multiple factors and challenges the women in this study faced in returning to work, as the following chapter will discuss.

CHAPTER 5

DISCUSSION

Overview

This chapter will summarize and interpret the findings within the context of the literature reviewed and provides a brief overview of feminist methodology. In addition, this section will examine and discuss (1) recurrent and emergent themes; (2) gender discrimination in the workplace and lower paying female dominated professions as larger contexts and institutions affecting women; and (3) what study participants suggested in terms of implications for practice, education, training, and policy. Lastly, this chapter will offer recommendations for future research.

Feminist Methodology

This study was unique in that the women participants had histories of interpersonal violence, experienced symptoms associated with PTSD, and were active recipients of vocational services from a state vocational rehabilitation program that assisted people with disabilities in returning to work. An extensive literature review found no other studies examining these circumstances; as such this study only begins to explore this topic, which requires further study. This exploratory study uses feminist methodology to provide an analysis that views gender as paramount and assumes that it affects women's working lives. A feminist mode of inquiry supports (1) discussing and analyzing women's experiences and placing them within particular social, cultural, and institutional contexts, and (2) identifying and discussing

commonalities and individual experiences and perspectives among women (Collins, 1991; Gergen, 1988; Harding, 1991; Hartsock, 2003). In this study the researcher generated recurrent themes, which were identified, categorized, and analyzed from participants' responses to the seven interview questions. Two peer experts checked each set of recurrent and emergent themes for accuracy, consistency, credibility, and believability.

Discussion of Findings

Each participant had a unique life story, and each spoke about her return to work within the context of trauma recovery and vocational rehabilitation. The women in the study were from diverse racial, educational, cultural, and economic backgrounds. For example, some women had graduate degrees, while others had earned a GED. Most of the women in this study had held steady employment at different points in their lives. However, at the time of the interviews only 3 out of the 15 participants held paid positions. One woman had stayed home to raise her children and had not held any paid positions.

Women in the study believed that their ability and/or inability to access resources significantly affected their decision making and vocational planning related to their return to work. Accessing resources to cover basic needs, health concerns, trauma recovery and treatment, and family and support systems were common themes and prominent factors for the women in this study. The literature supports this idea that accessing resources is a critical factor for women survivors returning to work (Brown et al., 2000; Chronister, Wettersten, & Brown, 2004; Gianakos, 2000).

Accessing Resources to Meet Basic Needs

Most of the women in the study were receiving public assistance in the form of disability benefits, transitional assistance, food stamps, and subsidized housing, but found that these institutions were difficult to navigate. Most reported frustration with accessing safe and affordable housing, adequate health care, transportation, mental health services, employment, and training. Participants believed, based on their experiences, that many of the systems and institutions were not sensitive to their needs and in some cases presented significant deterrents to application for services. They spoke at length about locating and traveling to and from agencies and government offices, completing forms, making phone calls, and following up with a range of personnel who worked within various agencies and institutions.

Some participants reported having relative success in accessing services to cover basic needs. For others, accessing services was extremely difficult. For example, one woman described herself as someone "who fell through the cracks" and also said she needed "negotiating skills." She spoke of frustrating social interactions she had had with people who worked at social service and health care programs and institutions. Most of these social interactions ended with her losing her temper, making it difficult for her to apply for services. Women who have PTSD symptomatology and who may be fragile or early in recovery may not possess the energy or knowledge to navigate and access the many complex and bureaucratic systems that cover basic needs such as food, housing, transportation, and health care. Although some women in the study who were living in shelters or sober houses

reported receiving some advocacy and case management to help access community resources, for the many of the homeless women finding safe and affordable housing was a priority and took precedence over finding employment.

Health Concerns

Many participants in this study were concerned about health issues as they related to returning to work. Several participants reported having multiple health issues. Prior studies supported the findings in this study that show that women survivors are at risk for multiple health issues such as cardiovascular, respiratory, musculoskeletal, and neurological conditions (Hegadoren et al., 2006; Resnick, 1997). Hegadoren et al.'s (2006) study on health issues affecting woman survivors found that medical conditions such as diabetes, gynecological issues, arthritis, cancer, and hepatitis C were common among women who have histories of interpersonal violence.

Some participants believed it was important to treat medical conditions before starting training programs or returning to work. One woman stated that she needed to have a hysterectomy and wanted to schedule eye and dental appointments before she returned to work. She believed that taking care of her health had to be in the "forefront" so she could prepare herself to "get back into the workplace." Many of the women were unable to keep their jobs or had had to drop out of school due to health issues. The participants' comments suggest that adequate treatment and/or resolution of women's health issues may prepare them psychologically and offer them the confidence they need to follow through with employment plans so they can achieve their vocational objectives.

Unfortunately, many poor women do not have the option of waiting to resolve health issues before returning to work. Regardless of their unresolved health issues, some women must go back to work, whether they are ready or not, in order to support themselves and their families. Some women return to work without medical treatment because they simply lack access to affordable health care.

Trauma Recovery and Treatment

For a significant number of participants, trauma recovery and treatment were important factors in their vocational rehabilitation and successful return to work. Along with taking care of health issues, some participants believed their recovery and treatment took priority over engaging in training programs or returning to work. This was particularly the case for participants who were struggling with PTSD, substance abuse, and/or other severe forms of mental illness.

Most of the participants struggled with depressive symptoms and believed that such symptoms sapped their initiative and energy reserves, making it difficult for them to develop support systems and engage in career decision making, training, or job search activities. One woman who was being treated for depression stated that she tends to isolate herself from family and friends and had difficulty leaving her house to participate in job-seeking activities.

Many of the participants reported experiencing combinations of mood disorders, dissociative disorders, anxiety, and substance abuse. Participants who reported comorbidity of disorders reported that their overall functioning was negatively affected, along with their ability to obtain and retain employment. Research in this area has shown significant impairment among women who have

PTSD symptomatology and a "co-morbidity of disorders" (Courtois, Ford, & Cloitre, 2009; Orsillo et al., 2002). Mental health treatment is essential to women survivors' recovery, particularly for those who are challenged by multiple disorders. Not surprisingly, participants in the study reported having significant difficulties in securing mental health treatment. Some participants reported that their mental health treatment was inconsistent, a situation often caused by their receiving medical care at training hospitals from student interns, who often leave at the end of the school year. Other participants were unable to keep their long-term therapists because their health insurance did not cover the cost of therapy.

However, as this section indicated earlier, many participants in this study understood the importance of treatment and trauma recovery. These women also knew that successful recovery and treatment are more likely to lead to successful vocational rehabilitation and returns to work. This finding is consistent with research that shows a positive correlation between trauma recovery and a successful return to work. For example, Fogarty and Beck's (1995) article, "Work Adjustment for Individuals with PTSD," recommended that survivors learn prevocational cognitive and behavioral interventions to help manage stress on the job. Other researchers have recommended a comprehensive approach that includes treatment and community services (Allen et al., 2004; Brown et al., 2000; Chronister et al., 2004; Gianakos, 1999).

Family and Other Support Systems

Participants in this study also reported receiving varying degrees of support from family and other sources. A study by Hall (2000) on urban, low-income trauma survivors with histories of substance abuse showed that lack of support and inability to access resources was a "significant barrier" that negatively affected "job readiness." This finding was particularly relevant for participants in this study who were homeless and who were early in sobriety. However, participants in this study without substance abuse histories also reported estrangement from family, social isolation, and minimal support systems.

Participants with children spoke at length about their relationships with their children. Interestingly, all the homeless women in the study reported having children. Some of the participants had become estranged from their children and families due to domestic violence, trauma, addiction, and mental illness. The topic of children was emotionally charged, and some participants became tearful when discussing their children. Poehlmann's (2005) study on incarcerated mothers and the influence of family contact on maternal depression showed that mothers' "limited contact" with and "relationship disconnection" from children was associated with an increase in depressive symptoms and a decrease in women's "psychological well-being" (p. 355).

In the present study as well, participants' separation from their children caused significant emotional distress. Participants expressed great heartache and were desperate to reconnect with their children. For these women, any decision regarding recovery and return to work was inextricably linked with their children's health and well-being. Some of these women's children were also coping with mental illness,

substance abuse, incarceration, and learning disabilities. Some of the participants with children were embroiled in contentious divorce and child support court proceedings. Some of these women were involved in these complex legal disputes with their ex-husbands, who, in most cases, were also their primary abusers. Other participants reported their experiences with courts and legal system and believed that these systems did not support them and that as a result they had lost custodial care of their children.

Returning to work was extremely important for participants who had lost custodial care of their children. These women expressed hope that they could rebuild their lives with their children. Some participants in the study believed that their children served as the main impetus for them to stay sober and make a strong commitment to recovery and return to work. The study by Babcock, Roseman, Green, and Ross (2008) showed that women who have good relationships with their children in terms of social support may fare better in their recovery and in achieving vocational objectives in order to return to work. These findings seem to be true for some of the women in the study. Some participants stated that they received significant support and encouragement from their children in their efforts to return to college.

Gender as a Factor in the Return to Work: Gender Discrimination in the Workplace and Female-Dominated Professions

Participants disclosed what occupations and careers they were interested in pursuing, as well as describing challenging experiences they had had in workplaces

they found to be unsupportive, discriminatory, or abusive. Gender was a recurring theme in their stories.

Institutionalized gender discrimination in the workplace results in pervasive and persistent pay inequities between men and women. According to the 2007 report of the U.S Bureau of Labor Statistics, women between the ages of 35 and 54 earn between 75% and 77% of men's earnings and are mostly employed in the education, health care, and social assistance industries. Female-dominated professions (also derogatorily known as “women’s work”) offer lower pay than male-dominated occupations (Hartsock, 1997). Gibelman (2003), in her article on pay inequities and gender discrimination in the workplace, stated that "gender gaps in salary have existed throughout history in all occupations" (p. 22). Gibelman also discussed society's failure to create policy and pass federal legislation that guarantees equal work for equal pay. As a result, "salary inequalities" between men and women persist (Gibelman, 2003, p. 25).

Most women in the study were either currently working in or pursuing careers in female-dominated professions. Some women in the study were pursuing occupations in counseling or clerical and administrative positions. They also reported wanting to work in jobs where they held roles of helping and care giving. Studies have suggested that women choose female-dominated professions based on early socialization, preferred interest, parental influences, role models, and/or relational identity (Betz, 1987; Coogan & Chen, 2007; Quimby & DeSantis, 2006; Rees, Luzzo, Gridley, & Doyle, 2007; Su, Rounds, & Armstrong, 2009). Although “women’s work” pays less, the benefit for many of these women was the “feminine” work

environment and work culture. Many women in the study preferred occupations and jobs in work environments that fostered team work, collegiality, and cooperation. Chronister and McWhirter (2003) and Coogan and Chen (2007) suggested that Bandura's social cognitive theory (SCCT) provides a framework with which to consider multiple factors such as sex or ethnicity, environment, and learning experiences, and their influence or impact on career interests and career choices.

It is my view, based on reports from participants in this study, that experiences of abuse also play an important role in women's occupational choices, perceived safety, and comfort level in certain work environments. Many participants reported feeling isolated and disconnected from their communities. They wanted to feel productive and to reconnect by returning to work. Other women may have a strong and overriding concern for personal safety that influences their career and occupational choices. Few if any studies have specifically examined how women's histories of abuse impact career choice. Some women in the study discussed situations and interactions at work in which they were harassed and felt unsafe. One woman in the study spoke of her experiences working as a printer in a male-dominated environment where she was sexually harassed and verbally abused. Interestingly, she is currently working in direct care in a residence for developmentally disabled adults and is satisfied with the job. This example suggests that women abuse survivors may choose more relationally oriented and cooperative work environments over careers and/or jobs that are male-dominated and higher paying. Coogan and Chen, in their article on career development for women, suggested that discrimination, sexual harassment, and lack of childcare may influence

career decisions and serve as barriers to women's career development. Women survivors may want to avoid internal and external triggers that symbolize or resemble trauma events, therefore avoiding work environments that trigger PTSD responses.

Harmon and Meara's (1994) chapter titled "Contemporary Developments in Women's Career Counseling: Themes of the Past, Puzzles for the Future" offered explanations for why women may be reluctant to enter male-dominated professions. Although this article was written sixteen years ago, the subject matter is relevant to this study and speaks clearly to the experiences of the women in this study. The authors discussed the difficulties women experience in male-dominated work cultures, which may have incompatible and "informal structures of communicating (e.g., sports language or jokes involving sexual innuendo)" that women may find "uninteresting" or "offensive" (p. 358). These authors also suggested that men may not be comfortable giving up "power" or may perceive "loss of control" as a result of changing their work behavior toward women coworkers (Harmon & Meara, 1994). Women survivors may choose to enter female-dominated fields for many reasons, but it seems that women survivors in this study wanted to feel connected, comfortable, and safe in their work environments. The harsh reality is that although women may feel comfortable working in female-dominated industries, they are likely to earn lower wages in such jobs.

Gender discrimination and women's occupational choices have multiple implications for practice, education, and training and policy. Counselors, academics, policymakers, and legislators should also be aware of the ramifications of women's career choices on their economic status and financial stability. Many workplaces are

hegemonic institutions that perpetuate gender discrimination that negatively affects the lives of working women. From a feminist perspective it is imperative that mental health and vocational rehabilitation counselors, policymakers, academics, and legislators do not fall into the trap of "blaming the victim" and understand that gender oppression is pervasive, systematic, and institutional, profoundly impacting the lives of poor working women. Professionals and policymakers need to go a step further and become activists to work changes in institutions to ameliorate gender discrimination and other barriers to women returning to work.

Implications for Practice

What women said in this study has critical implications for mental health and vocational rehabilitation counseling practice. It is important to acknowledge that mental health counselors and vocational rehabilitation counselors have distinct training and areas of expertise. Both play a critical role in women trauma survivors' successful return to work.

General Counseling Practice

I have observed from working in human services that over the last ten years there has been a devastating and widespread decrease in government funding for social programs. Unfortunately, this funding reduction has left helping professionals doing more with less. Mental health and vocational rehabilitation professionals are dealing with larger caseloads, dwindling resources, and increased administrative responsibilities. These constraints often get in the way of counseling professionals' ability to serve their clients adequately. In addition to becoming aware of the social,

cultural, and political barriers to women survivors' return to work, helping professionals need to learn what is helpful from the women themselves and within the context of many constraints.

Counselors also need to be cognizant of the impact of work environment on women's work functioning. Work environments and work cultures have hierarchical chains of command and built-in power differentials between managers, supervisors, and supervisees. Employers and supervisors have the power and control to make decisions about hiring, evaluating, and firing. Women find themselves dependent on and at the mercy of employers for financial support for themselves and their families. This dependency on employers and supervisors for financial support for survival may parallel prior relationships with abusers on whom they were dependent for the fulfillment of their basic needs.

Counselors need to understand that adaptation to the workplace is a requirement for successful participation and in order to obtain and retain employment. Women who have abuse histories may experience difficulty tolerating work demands and environments due to the combination of PTSD symptomatology and stress experienced on the job. Many of the women in this study experienced multiple and severe symptoms associated with complex PTSD and the demands of coping with a range of issues related to trauma recovery. Many participants were socially isolated and felt invisible, marginalized, and cast out of their communities. Some participants were better able to manage stress related to work, while others experienced great difficulty. Some participants had difficulty coping with triggers and intense emotional

responses to stress, which in some cases led to fatigue, frustration, and interpersonal conflict on the job.

For instance, one woman described her “work record” as a “roller coaster ride . . . it’s been 3 months here, 4 months there . . . I think the most I’ve ever worked consistently was a year.” She also stated that if the “stress level becomes too much” on the job her “body attacks itself, and it just kinda drops out.” Another woman who had a steady employment history believed that the stress of supporting herself and going to school had kept her from completing a printing internship at a local college.

Like, I went to school, again, tryin’ to get back in the business of printing, and I was doin’, um, direct care work at the same time, only part-time, and then I had a project that I had to do as an internship, and I was so stressed . . . I just can’t learn like I did when I was younger . . .

Another woman stated that she couldn’t think “of too many jobs where I didn’t get fired . . . I’ve been working since I’ve been about 17 years old.” She described instances on jobs when her “posttraumatic goes into overload . . . I lose my temper . . . I get frustrated . . .” She also stated, “I don’t have enough support, and then I don’t know what to do.” Other participants had careers and steady work histories but were unable to hold jobs due to addiction and subsequent incarceration. For these women, their recovery was paramount.

Another reality for some of these women was harassment and bullying on the job. One woman spoke about how closely her self-esteem was tied to her self-image. She also discussed at length the years of discrimination and abuse she endured at the hands of her boss.

I never even looked that good when I was young and single . . . it was in my forties that I lost the weight . . . I was always heavy when . . . I first worked for the doctor. He treated me better. But to, to weigh a lot, and then to lose the weight and actually see . . . this man treating me with more respect. . . it angered me, really, . . . cause I really got thin, and . . . it brought all my self-esteem up, and I felt really good, and I thought I had it all together . . . I didn't like the way . . . he treated me good . . . I resented the fact that . . . I had to be skinny for him to treat me better.

Counselors need to understand the impact of harassment and sexism on women's lives and their ability to sustain employment.

Other participants expressed the importance of counselors' being compassionate and respectful. One woman who had a long history of domestic violence said that it "took [her] a long time to trust" helping professionals in order for her to feel comfortable enough to open up. She described counseling situations in which she felt invisible: "They interview me, and my problem is when people don't look at me, or don't seem like they're payin' me any attention, or they not noticing anything about me." Although some women found counselors unhelpful, many of the participants valued the relationships and support they received from their counselors. The Implications for Mental Health Counseling and Vocational Rehabilitation Counseling sections of this chapter will discuss in more detail what participants reported as helpful, including clinical interventions and vocational strategies.

Many participants reported concerns about losing disability benefits, suggesting that helping professionals should become knowledgeable about Social

Security disability benefits eligibility and guidelines. This knowledge is crucial and should become part of standard practice for mental health and vocational rehabilitation counselors so that they can help clients make informed decisions about their benefits and the return to work. Professionals should refer women to community benefits specialists who can explain Social Security eligibility and guidelines in terms of employment. For example, in Massachusetts, the Social Security administration has funded a grant entitled Project Impact. Project Impact was developed to provide "benefit planning, assistance, and outreach for persons with disabilities who receive SSI or SSDI and are interested in working or returning to work" (http://www.communityinclusion.org/project.php?project_id=23). Counselors should be aware of government- and community-based programs that provide for people with disabilities who are returning to work, while being cognizant of the fact that many programs are seriously underfunded or often unavailable.

The participants in this study wanted help with decision making around evaluating their readiness to return to work, seeking satisfying careers, and finding compatible work environments. Helping professionals can play a critical role in assisting women with making good decisions and planning for the return to work. As studies by Chronister (2006) and Sullivan and Albee (1999) have shown, short-term and long-term planning are vital to a successful return to work for women leaving abusive relationships. Personal safety and financial independence were of great concern for participants who had recently left their abusers. However, short-term vocational objectives are important and may include finding paid employment quickly so that a woman can financially support herself and her family, thereby

making her more likely to leave the abusive relationship. This may be particularly true in cases where an abuser is also the primary source of financial support. Short-term employment goals may not necessarily take into account whether a job is a good fit in terms of women's interests, aptitudes, and abilities; rather, they aim to break the cycle of violence (Chronister et al., 2004). Long-term vocational planning is important because it provides women with opportunities to explore and pursue careers that are satisfying, meaningful, and more lucrative. Higher-paying jobs are more likely to lead to long-term financial stability.

Some participants discussed their age as a significant factor in returning to work. Counseling professionals should be aware of the real challenges older women face when returning to the workforce. All of the women in this study were of middle age, ranging from 38 to 61 years old. One woman was starting a new career and worried about the competition for jobs in her field, particularly in regard to being passed over for jobs by younger candidates applying for the same position. Another woman wondered whether she would be able to fit into a work culture composed primarily of younger workers. Other participants had difficulty trying to "fit in" and adapt to work environments dominated by men. One woman spoke of her experience working at a factory, staffed mostly by men, where she was subjected to taunts and sexual harassment by male coworkers.

Helping professionals should be aware of the devastating and retraumatizing effects of workplace harassment, bullying, and age discrimination. While helping professionals may be powerless to intervene directly in cases of hostile work environments, they may, through awareness of these issues, assist and guide women

as to what to do in difficult work situations. Helping professionals can refer women to community and government organizations for legal advice and assistance regarding protective harassment and gender discrimination laws. For example, in Massachusetts, the Massachusetts Commission Against Discrimination exists to provide assistance to "citizens and businesses" and to "enforce laws prohibiting discrimination on the basis of race, color, religion, national origin, ancestry, sex, age disability, sexual orientation, genetics, or past involvement in a discrimination complaint" (<http://www.mass.gov/mcad/faq.html>). Counselors should have a list of resources for local and governmental agencies to educate women about and protect women from hostile and exploitive work environments and practices. Counselors should also be aware that these resources may be limited. Given the dearth of services, counselors should also take an activist role to increase these vital services and supports.

Mental Health Counseling

Some study participants believed that the supportive counseling and trauma counseling they received from mental health counselors was critical to their ability to return to work. Supportive counseling increased participants' self-esteem and created positive self-images. Trauma counseling helped participants improve interpersonal and negotiating skills, develop healthy boundaries, manage stress, challenge negative beliefs, and safely process traumatic experiences. Studies have shown that a positive self-image is important for new learning, skill building, and risk taking in addition to successfully seeking employment and participating in post-secondary training (Brown et al., 2000; Chronister et al., 2004; Gianakos, 1999). Some women in the study

perceived trauma counseling as facilitating their preparation for returning to work and work functioning while on the job.

Some participants in the study were not satisfied with their mental health counseling experiences. They expressed concern that their mental health counselors were either inexperienced or unable to provide long-term counseling. Long-term therapy is recommended for treating people with severe forms of PTSD (Herman, 1997). Continuity of care seems fundamental to effective trauma recovery counseling for women trauma survivors, and its presence or absence has a significant impact on their vocational rehabilitation outcomes (Chronister et al., 2004; Sullivan & Bybee, 1999). Mental health counselors who are not adequately trained in trauma therapy may not be able to provide women with strategies and interventions that reduce PTSD symptoms that often pose major barriers to the return to work. Poor women, in particular, are more likely to receive counseling from training hospitals that employ student interns. Student interns may lack clinical experience and often leave at the end of their practicum/internship, forcing clients to switch to a new therapist and rebuild the therapeutic relationship. One solution may be that women survivors who need long-term intensive therapy and are receiving treatment in a teaching hospital could be assigned to experienced staff clinicians so that they receive adequate and consistent therapy.

Women survivors may benefit from learning negotiating skills so that they can effectively advocate for themselves by applying and/or retaining benefits and services from public agencies. Albaugh and Nauta's (2005) research on college women's experiences of domestic violence indicated that these women found conflict

negotiating skills helped them communicate and assert themselves more effectively with significant others. Researchers have also recommended cognitive behavioral interventions as helpful to women survivors in navigating stressful situations and increasing interpersonal functionality. For example, dialectical behavioral therapy (DBT), developed by Marsha Linehan (1993), works to improve emotional regulation and interpersonal and communication skills. One woman in the study was participating in DBT training. She believed it was helpful in terms of "dealing with people" and setting healthy boundaries in relationships.

It is important to note that most psycho-educational and clinical interventions are not free of cost. Women seeking to access these types of trainings and programs must either self-pay or have health insurance that will cover its cost. Women survivors of abuse, who already face challenges that undermine their ability to procure employment, face a catch-22 in seeking mental help: they often cannot afford the assistance that will enable them to improve their financial circumstances.

Vocational Rehabilitation Counseling

Study participants believed that the counseling, guidance, sound planning, and encouragement they received from vocational rehabilitation counselors were helpful in terms of the return to work. Some participants reported having good relationships with their vocational rehabilitation counselors, which instilled hope and optimism about the participants' futures and encouraged them to take steps toward obtaining satisfying and meaningful employment. While vocational rehabilitation counselors receive training in addressing a range of mental and physical disabilities affecting

employment, they may not have had training in or be aware of women survivors' circumstances and vocational needs within the context of trauma and recovery.

Some participants in this study found vocational assessment helpful because it identified career interests, abilities, and limitations. In the existing literature, vocational assessment emerged as important to women's career exploration and vocational planning (Chronister, 2004; Gianakos, 1999). Workshops and trainings that improve interpersonal skills for dealing effectively with conflicts on the job may be helpful as well. A few participants found résumé writing assistance helpful. One participant gained tremendous insight from the résumé-writing process, as it afforded her the opportunity to view and evaluate her work skills, work aptitudes, and career interests objectively. Other participants believed they had benefited from one-on-one supported job searches with job placement specialists. One woman found it helpful to meet regularly with a job placement specialist. She believed that the meetings kept her focused and helped her follow through with job search activities. Another woman expressed interest in having regular meetings or "check-ins" with a job placement specialist while working. She believed the "check-ins" were helpful because she could discuss issues and receive feedback related to daily work functioning, such as appropriate work behavior and navigating interpersonal relationships with coworkers and supervisors.

Comprehensive services, including short-term and long-term planning, training, and long-term employment, are key to women survivors' breaking the cycle of violence, achieving financial stability, and finding employment (Chronister, 2006; Chronister et al., 2004; Sullivan & Bybee, 1999). Long-term vocational planning may

include post-secondary training to help women build their skills and allow them to compete for better-paying jobs. State vocational rehabilitation counselors are expected to achieve predetermined quotas and a certain number of job placements. Unfortunately, such standardized performance measures may pressure vocational rehabilitation counselors to emphasize short-term planning for clients and suggest jobs that may not provide adequate financial stability or take into account their clients' unique needs, career interests, skills, and abilities. Ideally, vocational rehabilitation counselors should be cognizant that both short-term and long-term planning are critical for women survivors' successful return to work. Vocational rehabilitation counselors should provide their clients with comprehensive planning. Comprehensive planning includes systems that facilitate good communication and collaboration of services between mental health and vocational rehabilitation counselors and other providers who work with women survivors. The following section will address this topic further.

Implications for Education and Training

My experience as a vocational rehabilitation counselor and mental health trainee suggests that extensive collaboration and regular communication between vocational rehabilitation and mental health professionals is extremely helpful to women survivors. Trainings and forums that permit collaboration between mental health and vocational rehabilitation counselors may be helpful and encourage better communication, knowledge sharing, and service coordination. Other helpful forums

and collaborations may include the participation of women survivors and advocates to provide firsthand accounts of their experiences.

Implications for Policy

Most of the women in this study reported that systems and larger influences affected their returns to work. Some of the larger institutional influences they cited included the structure of Social Security benefits; the availability, affordability, and quality of health care; finding affordable housing; and their current work cultures and environments. A number of participants complained about being burdened by bureaucracy and the overwhelming amount of "paperwork" they had to complete to access and keep their benefits. As this chapter discussed earlier, many participants identified a range of public institutions and systems that were difficult to access and constituted significant factors in their return to work. One woman who was receiving disability benefits stated:

You know, if you decide to go back to work and, you know, you don't fully know if you can, then you're gonna risk the chance that they're gonna take the Social Security away, and leave you without the medical, because some jobs don't have medical . . . medical's very important to me, to anybody on disability.

The women in the study who were receiving disability benefits expressed caution about returning to work. They were concerned that once they started working they might earn more than the predetermined substantial gainful activity (SGA) level cap per month. Earning beyond this cap may result in the reduction or termination of

benefits. The Social Security Administration's (SSA) work incentives program does offer people with disabilities who are interested in returning to work the chance to work for a 9-month trial period, during which time they are allowed to keep their benefits regardless of earnings during this period (<http://www.socialsecurity.gov/disabilityresearch/wi/generalinfo.htm>). However, this work incentive may negatively affect people with chronic mental illness, who may have lengthy periods during which they are able to work beyond the SGA interspersed with other periods during which they are unable to work. It is important that SSA work incentives have the flexibility to take into account the cyclical nature of some forms of mental illness.

The participants in this study who were receiving disability also had full Medicare health care coverage. Many feared that if they returned to work and earned more than the SGA amounts they would not be able to retain their current levels of health care coverage without paying additional costs. Poor women often cannot afford to pay more than their current budget permits for health coverage and may choose not to work or to remain underemployed in order to keep their current health care coverage.

For most of the women in the study, returning to full-time employment was not an option because the cost was too great. Many of the women in the study who were working and receiving benefits chose to work part-time and/or in low-paying and entry-level jobs so as not to earn over the SGA cap. The responses of participants in this study suggest that the SSA work incentives program needs to be revamped. Increasing the current earning caps and lifting the restrictions on the trial period may

provide more incentives toward employment for people with disabilities who are interested in returning to work.

Affordable housing was another critical concern for participants. Without safe and affordable housing, women may be less able to participate in vocational rehabilitation. Participants who were living in shelters or other unstable housing arrangements were especially challenged. They complained of not feeling safe and/or suffering from sleep deprivation. Without safe and affordable housing, it may be difficult to think about other basic needs, much less pursue career interests and training. Without a permanent address and a safe place to sleep, many women survivors will continue to find the return to work elusive.

The policy solution is to create more safe and affordable housing. One woman described her experiences with domestic violence. She was homeless and living in a local shelter at the time of the interview. She spoke about leaving her abuser and the pain of losing her children, home, and community. Her anger and frustration were palpable when she spoke of the lack of assistance and services available to women survivors. She wanted to warn other women about the negative consequences of leaving their abuser. She suggested that women might want to stay with their abuser so as not to "lose everything." Unfortunately, this experience may not be uncommon for many domestic abuse survivors who "fall through the cracks" and find themselves without a "safety net" to prevent them from "losing everything." This is indicative of a culture that seems to be more interested in profits than the welfare of the working class and poor—especially disenfranchised women.

Some women in the study stated that they could benefit from more accommodation and support on the job. High unemployment, the currently shrinking labor market, and the recession may mean, however, that employers are less inclined to go out of their way to make accommodations for employees. It is an employers' market and climate, in which employers can more easily screen out, lay off, and fire employees at will. One participant believed that she would "need a lot of support" to keep a job and would benefit from

someone consistently, more or less, being there with me, guiding me, um, with my stress levels, checking in, if you will . . . there's no job that provides that. You go to work for Home Depot or Lowes, or this company or that company, they don't care, they want you to produce so that, you know, they get their profit . . . You know, that's the corporate world.

In the case of companies that hire people with disabilities, some work environments may prove to be less than ideal and supportive. One woman survivor who had a history of mental illness spoke of a job she obtained through her vocational rehabilitation counselor:

I went in there, through Mass. Rehab . . . which I kinda wish . . . I didn't . . . because everybody knew I came from Mass. Rehab, in the company . . . and like they're fishin' around, seein' if I'm a convict or somethin', so finally I came out and told them . . . and, um, and I was kinda treated a little different . . . I think people do have a preconceived notion of someone who has a mental illness.

Even companies with progressive policies about hiring people with disabilities sometimes perpetuate stigmas and stereotypes about mental illness.

As I reflect on my experience as a graduate student and my years working in the field, I note significant tensions and differences between academia and the field when it comes to particular standpoints, perspectives, positions, and roles. Stricker and Trierweiler (2006), in their article “The Local Clinical Scientist: A Bridge between Science and Practice,” discussed “the tension between the scientist's public quest for generalized knowledge and the practitioner's private quest for specific application” (p. 44). For women and for those of us working in the field, it is critically important that research produces practically applicable solutions and strategies that take into account the existing resources. Put simply, women and those in the field need to know what works in “the here and now.”

Clients, counselors and advocates, and others who work in the field are often not in positions that give them the power to shape directly the current policies in oppressive and failed systems and institutions. For this reason, those who are in positions of power and can effect social change (that is, researchers and politicians) must remain connected, listen, and in some instances take their direction from field practitioners. Helping professionals working with women survivors, as well as women survivors themselves, need to know what works when it comes to the treatment and management of PTSD's effects in the workplace. This means identifying effective strategies and finding existing resources that support women survivors' vocational rehabilitation and return to work. Future research should focus

on creating systems that will facilitate effective communication and collaboration between academics and helping professionals who work in the field.

Limitations and Recommendations for Future Research

There is a need for further research and development of theoretical frameworks and models to assist women survivors returning to work. Chronister and colleagues are among the few researchers who have conducted studies in this area. Also, as chapter 4 discussed, the effect of my dual role as a vocational rehabilitation counselor and researcher on women's responses requires examination. On the one hand, I was able to draw on more than 20 years' experience in vocational rehabilitation. My expertise gave me a deep understanding of the complexities and challenges of individuals' adjustments to disability within the context of returning to work. On the other hand, it is possible that my position and experience as a vocational rehabilitation counselor reinforced my belief that work plays a critical role in trauma recovery. My perspective has been shaped by my experience and knowledge. Undoubtedly, my perspective (as is true of all perspectives and viewpoints) comes with "blind spots." I struggle with and am conflicted about my role as a counselor for a state vocational rehabilitation program whose mission is complicit in perpetuating western capitalism and its manipulation of the labor force in order to gain large profits (Harding, 2004; Hartsock, 1998). I find myself complicit in supporting systems that in fact oppress and marginalize the very people I serve. Nonetheless, such inconsistency is a living reality for those of us who work in the social service field. We must continue to critically examine our own positions, which are shaped by

our experiences and relationships as workers within systems and institutions. This awareness is precarious and difficult because it causes us to critique the systems and institutions that constitute our livelihoods, reward us, and directly affect the quality of our lives.

However, my role as a researcher is to pursue knowledge using a qualitative and feminist theoretical framework and methodology. My intent in using a feminist methodology for this study was to empower women participants by giving them a voice and making their experiences in returning to work central to the study. What the women actually said in their interviews provided keen insights into what they perceived to be helpful for and barriers to employment. My overarching hope for this study has been and remains that the insights it yields will improve the quality of life for women survivors.

My first recommendation is that future research should examine institutional barriers that impact women trauma survivors' return to work. More specifically, research should investigate the efficacy of public institutions, service delivery systems, and policies that provide basic services to the poor and disabled (for example, housing, Social Security, and healthcare). Many of the women in this study found that the Social Security work incentive program offered more disincentives than incentives and considered it a significant barrier to employment.

Second, new research should focus on the development of training and forums that bring mental health and vocational rehabilitation professionals together to collaborate and share their expertise. These trainings should educate and inform counselors about pervasive political and cultural institutional barriers to employment

for women who experience symptoms associated with PTSD, including but not limited to gender discrimination in the workplace and lack of access to community resources. The trainings and forums should also recommend ways in which mental health and vocational rehabilitation professionals can advocate for clients to each other, coordinate services, share resources, and strengthen communication in order to develop comprehensive plans that address women's needs in terms of recovery and vocational rehabilitation.

Third, I recommend the continued education of employers on (1) the impact of domestic violence on work functioning; (2) appropriate accommodations and support on the job so that victims of domestic violence can retain employment; and (3) existing laws that protect employees against discrimination, bullying, and harassment on the job.

Fourth, more research should take place on developing effective training and education for vocational rehabilitation professionals regarding the effects of PTSD and domestic violence on women returning to work. Additional research and training should examine the efficacy of short-term and long-term vocational planning for this population.

Fifth, more research should take place to develop educational training for mental health professionals that identifies counseling approaches aimed at helping prepare women survivors for and assist them in the return to work. Such research could include the development and implementation of cognitive behavioral approaches that improve problem solving and interpersonal skills specific to the workplace. Additional research should address the importance of vocational planning

in helping mental health counselors assess clients' work readiness so as to develop realistic vocational goals.

Finally, I recommend that a researcher not employed by a mental health organization or vocational rehabilitation agency providing direct services to women trauma survivors may profitably duplicate this study. Such research may supplement, confirm, or contradict this study's findings. Other future research may include duplication and expansion of this study by interviewing different populations (for example, male and female veterans challenged with PTSD) to further examine gender and perceived barriers and facilitators to employment and their influences on recovery and the return to work.

Further feminist qualitative research based on women survivors' own experiences and words should take place in the areas of interpersonal violence, PTSD, and women survivors' return to work. This type of research foregrounds the need for change at the social, cultural, and institutional levels. I do not doubt that efforts toward social change and social justice will encounter resistance. In fact, resistance to change may come from the very structures and social institutions that exist to improve the quality of life for women trauma survivors. Efforts must continue on every front, from counselors to legislators to women survivors, to raise awareness and critical consciousness about how institutions and the people within them directly influence the working lives of women survivors. In this way, change can occur to eliminate barriers to this population's employment.

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APPENDIX A

INTERVIEW QUESTIONS

Women Trauma Survivors' Experiences of Returning to Work

IQ 1: I'm interested in knowing about your work experiences (i.e. paid, unpaid-volunteer, internships). Of all of your work experiences, what made them successful? What made them difficult?

IQ 2: What are some factors you have had to consider in making decisions related to your return to work (i.e., family, education/training, transportation, job availability, health issues)?

IQ 3: What has been helpful to you in returning to work? What has gotten in the way?

IQ 4: What is your experience of mental health counseling as you are preparing to return to work? Has it been helpful? What has been helpful?

IQ 5: What is your experience of vocational rehabilitation counseling as you are preparing to return to work? Has it been helpful? What has been helpful?

IQ 6: What would you like to tell professionals about what might be helpful to the return to work?

IQ 7: What would you say to other women about what was most helpful to your vocational rehabilitation?

APPENDIX B
BIOGRAPHIES

Molly

Molly is a 43-year-old divorced Caucasian woman who has a long history of symptoms associated with bipolar disorder, posttraumatic stress disorder, and substance abuse. She reports undergoing psychiatric hospitalizations through the course of her life. Molly's mother also had a severe form of mental illness and lived in a supervised residence. Molly is a victim of early childhood abuse and domestic violence. At age 23, she married a man she described as verbally abusive and "dominating"; she married partly to "keep him in the country": Her ex-husband immigrated to the United States from Poland. Molly is currently working part-time as a residence assistant at a supervised residence for developmentally challenged adults. She is working part-time so as not to disrupt her Social Security benefits, which include health benefits. She states that she enjoys this type of work because she enjoys helping people. Molly has enrolled in college training programs but has been unable to complete them. However, Molly has a steady employment history working in the printing industry, retail, food service, and customer service. At age 19 she started working as a scanner at a printing company and worked in a predominantly male environment. She describes this work experience as difficult because she was sexually harassed and subjected to verbal abuse on the job. She reports having a history of difficulty establishing healthy working boundaries with male bosses. She also found herself spending excessive amounts of on-the-job time and energy on

"worrying" and "trying to please people." Molly states that she is a different person now and has gained self-confidence. She is receiving good therapy and volunteering as a speaker for an advocacy group for people living with mental illness.

Anna

Anna is a 44-year-old single Latina woman who is currently being treated for posttraumatic stress disorder (PTSD). She has a high school diploma. She reported that she is unemployed and receiving Social Security disability benefits. She stated that work had been a challenge for her and described it as a "roller coaster ride." She has started jobs and found that she was "juggling too much," which has led to her eventually leaving and/or "dropping out" of jobs. She attributed this pattern to her PTSD. She reported that most of her employment has been in retail. Her longest commitment to a job was a year working as a salesperson at Verizon. She stated that she enjoys landscaping, art, and design. She believes that her last job working as a salesperson at a furniture store was a good fit except for the long hours. This position demanded a 50-hour work week. She was unable to stay on the job for more than four to five months. Anna expressed concerns about finding safe, affordable, stable housing. She believes that without adequate housing she would not be able to complete a training program. She also expressed concerns about returning to work. She was uncertain whether she could keep a job and expressed concern that if she were employed she might lose her disability benefits. She believes that PTSD is a "hidden disability" and that there is a general "lack of understanding of what posttraumatic stress syndrome is." She described her situation as that of "someone

who falls between the cracks" and struggles to meet basic needs such as food, housing, and transportation. Anna expressed ambiguity and uncertainty related to her future, her well-being, and her return to work.

Mary

Mary is a 44-year-old divorced Caucasian mother of four children between the ages of 17 and 28. She has a high school diploma. She reported having a chronic history of alcoholism, suicide attempts, and domestic violence. She is also coping with medical issues and being treated for fibromyalgia and pain related to neck and ankle injuries. She is currently homeless and living in a transitional housing program for alcohol and drug addiction. She is in the process of applying for subsidized housing. She described her ex-husband as an abusive alcoholic. She has been divorced for 17 years. Her four children live with her ex-husband in a southern state of the United States. She believes that she gets her strength and motivation from her children, whom she describes as being very supportive. She believes that her outlook on life is much better since she has her kids back in her life. Mary has been in the "restaurant business for 31 years" and has held manager, waitress, and bartending positions. She excels in this line of work and enjoys working with "people and the public." Since her injuries to her neck and ankles she has been unable to return to waitressing. She is making a career change and is currently enrolled in an alcohol /substance abuse counselor certificate program. She expressed concerns about being hired for substance abuse counselor positions because of her age and the competitiveness in the field.

Julie

Julie is a 54-year-old single Caucasian woman who is being treated for PTSD and diabetes. She reported having a history of child abuse and neglect. She is currently unemployed and receives social security disability benefits. She has a bachelor's degree and a professional actor's certificate. She reported having great difficulty retaining employment and stated that she "couldn't think of too many jobs where I didn't get fired." She has held a range of jobs and believes that stress triggers a high degree of frustration and anger while on the job. However, she reported having some success in acting jobs—because, she believes, there is more "latitude" in such jobs. She believes that she fits in well with other actors and that it is an environment that frequently offers more defined roles and responsibilities. She is estranged from her family and believes that she does not receive enough support. She mentioned an older sister, to whom she has not spoken in 20 years, who also has PTSD. She described herself as someone who can get jobs but not keep them. She mentioned making efforts to obtain support and develop better coping skills to manage her frustration and anger.

Christine

Christine is a 56-year-old divorced Caucasian mother of three adult children ages 23 to 27. She reported having a history of childhood abuse and is currently being treated for PTSD and anorexia. She also mentioned coping with an array of medical issues. She identified having a startle reflex and establishing healthy personal boundaries as some of the PTSD symptoms she struggles with in terms of her work

functioning. She stated that she has difficulty telling people when they cross over into her personal space and physically get "too close." She occasionally picks up odd jobs but has been mostly unemployed and receives Social Security disability benefits. She worries about her son, who has been diagnosed with ADD and substance abuse. Christine is highly educated, has a master's degree in counseling, and worked for many years as a psychotherapist. She has taken a number of entry-level retail, office/clerical, and volunteer positions. She struggled with working on some of these jobs because she believed that they were not a good fit relative to her interests and skills. Christine has experienced many periods in her life during which she became very sick, was unable to work, and required psychiatric hospitalization. However, throughout the many ups and downs associated with her illness she has been able to do volunteer work. She believes that volunteering is important because it keeps her connected and makes her feel as though she is "giving something" back.

Candis

Candis is a 49-year-old single Caucasian woman and a victim of domestic violence who is in treatment for symptoms associated with PTSD. At the time of the interview she was grieving the loss of a close friend who had died approximately one year before. She reported recently leaving abusive relationships and moving to another town to ensure her safety. Candis is a registered nurse and has been unable to return to the profession because she could not make a full commitment and meet the demands of the job due to "all of the domestic violence." Her long-term goal is to eventually return to nursing. She is currently working part-time as an office assistant

at a local hospital and has been working there for 12 years. She was granted a medical leave of absence by her employer. Her employer was aware of the domestic violence she was experiencing and held her position until she was able to return. She expressed concerns about her financial situation, health, and age. She has had to manage her expenses, including budgeting transportation costs. She also discussed her age in terms of being in midlife and the "loss of her youth." She acknowledged the importance of trauma therapy in her recovery and work functioning. She admitted to struggling with feelings related to reactions from coworkers when she returned from her leave. She described herself as "slightly vigilant" and "always watching" on the job. This behavior affects her work functioning, saps her energy, and causes her to become unfocused and lose track of the task at hand. She described an incident in which she wheeled a patient to another department to make sure the patient was "safe." Transporting patients was outside of her role as a clerical assistant; as a result, it compromised her ability to perform her clerical job.

Charlene

Charlene is a 41-year-old divorced Caucasian mother of two adult children ages 19 and 21. At the time of the interview, Charlene was homeless, living in a nearby shelter, and receiving Social Security disability benefits. She has a high school diploma. She reported having numerous psychiatric hospitalizations and has had difficulty finding satisfactory treatment for PTSD, domestic abuse, and somatization disorder. She reported being a victim of domestic abuse at the hands of her ex-husband. She reported having little to no work history since she got "sick." Before she

became ill, she worked as a teacher's aide in a "special-needs preschool." She reported that for most of her adult life she was at home caring for her children and "wasn't out in the workforce." She was clearly struggling with her recovery and expressed concerns about her ability to secure services to cover basic needs such as housing, food, transportation, and health care. Her anger and frustration were palpable as she described the many systems she struggled to navigate to cover her basic needs. She reported many examples in which she had difficulty effectively communicating her needs to human and social service providers, including therapists and service coordinators. She believes that she would be more effective at communicating her needs if she could "control her emotions" with better interpersonal and/or "soft" skills. She stated that she might not be ready to engage fully in vocational rehabilitation, believing that it was still early in her recovery and that she was in "the middle of trauma."

Gail

Gail is a 54-year-old single Jewish woman who has a history of early childhood abuse. She has a master's degree and has held many high-level "white collar" positions. She has held positions in real estate, marketing, project managing, fund raising, program developing, and grant writing. She is currently not employed and is receiving Social Security disability benefits. She recently completed paralegal training. She is the primary caretaker for an elderly parent and has made decisions about "reprioritizing" and balancing family responsibilities and her vocational rehabilitation. Her preparation for her return to work also has included organizing

herself and taking care of outstanding health issues such as having needed surgery. Before returning to work, she would like to visit the dentist, write a résumé, and buy new clothes for job interviews. She reported having a history of difficulty in developing good working relationships with superiors, who she perceived were "keeping" her "in a subservient situation." She described increasingly losing her patience on the job and becoming outspoken by showing her anger and frustration and damaging her relationships at work. She believes that as an older woman she will have to be more patient on the job when working in environments with younger and less experienced coworkers. In light of her challenges, she expressed a strong commitment to her recovery, rehabilitation, and readiness to return to work by taking active steps to find outside supports such as mental health counseling and vocational rehabilitation counseling.

Jen

Jen is a 47-year-old divorced Caucasian mother of two teenage daughters ages 14 and 18. She has an associate's degree and has worked as a radiological technician for most of her career. Jen has a long history of substance abuse and depression. She was in therapy for PTSD and substance abuse. She reported experiencing domestic violence at the hands of her ex-husband. She described her ex-husband as an abusive crack addict. She also has been challenged with medical issues. She has fibromyalgia and nerve damage in her arm from a repetitive motion injury acquired on the job. She eventually had surgery on her arm, which she described as painful and debilitating. At the time of the interview, she had been recently released from prison, was homeless, and was staying in a domestic violence shelter. She reported that was not working and

was receiving aid from the Elderly, Disability, and Children benefits program (EAEDC) to cover child support, food, transportation, and health care. After a contentious divorce, her ex-husband received custody of her youngest daughter. However, she remains close to both of her daughters and stated that she "talks to my girls every day." Jen expressed hope that once she "got stabilized" her daughters would live with her. She stated that she would like to renew her license so that she can continue working as a radiological technician.

Sandy

Sandy is a 51-year-old single Caucasian woman who has a history of childhood sexual abuse. She is currently being treated for PTSD, bipolar disorder, hypothyroidism, and juvenile diabetes. She reported being a "sex slave" during her childhood: She "wore little costumes and danced, and then got abused." She reported not having worked since 2006 and that she was receiving Social Security disability benefits. Sandy is a highly educated woman who earned a master's degree in social work and a law degree. She worked for ten years as a public attorney serving low-income families and children. She has not worked as an attorney since 2003. Her jobs have included being a paralegal, community organizer, secretary, and union organizer and holding various volunteer positions. She also reported a history of difficulty keeping jobs. She described having "relationship problems" in her jobs and stated that she became extremely "self-conscious" and fearful on the job. Eventually, she left all of her positions as a result of these issues. She stated that she wants to return to work

but is concerned about her lack of relationship skills, which she considers a significant barrier to keeping employment.

Francis

Francis is a 60-year-old divorced African American mother of six children. Two of the six children are deceased. Francis believes that depression related to the deaths of her two children also negatively impacted her ability to move forward in her vocational rehabilitation. She is currently receiving mental health counseling for PTSD, grief, and depression. She reported having been a victim of domestic violence at the hands of her ex-husband. She also spoke about her health issues and learning disability. She is a diabetic and experiences difficulty regulating her blood sugar, particularly while at school and work. At the time of the interview, she was not working and was receiving Social Security disability benefits. However, she spoke about two mental health internships she had completed through a college certificate program. Prior to the training program, Francis had held many jobs, but after she married she did not work. She believed that her education would help her support herself and her children. After the divorce, she took entry-level retail and customer service positions. She also earned a certificate as a nursing assistant and worked in health care. She acknowledged that getting and keeping jobs was never a problem for her, and she believed she knew how “present” herself for interviews. In addition to her health issues and pursuing training, she was concerned about losing her SSDI benefits if she returned to work. She described the return to work as a “catch-22” that

many people with disabilities face—that is, being limited in how much you can earn without jeopardizing benefits.

APPENDIX C

FLIER FOR CONSUMERS

*****Looking for Volunteers for an Important and Groundbreaking***
Study on Women, PTSD, and the Return to Work**

I am conducting a study on the experiences of women trauma survivors' returning to work and important relationship between work and recovery. The emotional and psychological impact of interpersonal violence (IPV) can significantly limit functioning and have negative effects on women's health and employment.

Your participation will help identify important facilitators/supports and barriers to employment for women who have histories of interpersonal violence that includes child abuse and neglect.

Your experiences are of value and hold important insights. The purpose of this study is to inform human service professionals and other women survivors as to what is helpful to the return to work for women trauma survivors. Sharing your story can make an impact on the lives of women survivors who want to return to work.

I am looking to recruit volunteers who are:

- Women between the ages of 25 to 65.
 - Active MRC consumers.
 - Receiving mental health counseling.
 - Have a primary diagnosis of PTSD.
 - Have command of the English language.
- * Participants will be paid \$25.00 at the completion of the approximately one-hour interview.
- * Confidentiality will be maintained at the highest levels and participation in this study will not affect your current status or services received at MRC.

I look forward to speaking with interested volunteers. For more information, or to volunteer, please contact:

Galina Gittens M.Ed., CRC.
MRC Somerville Office
(617) 776-2662 X332
Galina.Gittens@mrc.state.ma.us

APPENDIX D

PROJECT FLIER FOR COUNSELORS

*****Asking For Your Help********** Important Study on Women, PTSD, and the Return to Work*****

I am a doctoral student in Northeastern University's Counseling Psychology program and a MRC vocational rehabilitation counselor. I am conducting a study on the experiences of women trauma survivors' returning to work. I am requesting VR counselors' participation in this study to identify MRC consumers who meet the study's selection criteria and who may be interested in becoming a volunteer.

Why This Study Is Important

According to the Centers for Disease Control and Prevention, National Center for Injury, research has shown that there are approximately 5.3 million incidents of interpersonal violence (IPV) among U.S. women ages 18 and older. Additionally, two in five women experience at least one type of abuse or violence in their lifetime. Thirty-nine to eighty-five percent of women with disabilities experience some form of caregiver or intimate partner abuse. However, few studies specifically focus on how interpersonal violence and the psychological impact of trauma affect the working lives of women.

I am looking to recruit women volunteers who are:

- Active MRC consumers.
- Between the ages of 25 to 65.
- Receiving mental health counseling.
- Have a primary diagnosis of PTSD.
- Have command of the English language.

Participants will be paid \$25.00 at the completion of approximately one hour interview. Confidentiality will be maintained at the highest levels and participation in this study will not affect in anyway MRC consumers' status or services. This study is approved by the Area Director and the Deputy Commissioner.

Thank you for your interest in this important study. For more information contact:

Galina Gittens M.Ed., CRC.
MRC Somerville Office
(617) 776-2662 X332
Galina.Gittens@mrc.state.ma.us

APPENDIX E

PROJECT CONSENT FORM

Northeastern University, Department of Counseling Psychology
203 Lake Hall

Investigator: Galina E. Gittens

Title of Project: Women Trauma Survivors Experiences of Returning to Work

Consent Form for Research**Informed Consent to Participate in a Research Study**

I am inviting you to take part in a research study. This form will tell you about the study, but I will explain it to you first. You may ask me any questions you may have. When you are ready to make a decision, you may tell me whether you want to participate or not. You do not have to participate if you do not want to. If you decide to participate, the researcher will ask you to sign this statement and will give you a copy to keep.

Why am I being asked to take part in this research study?

I am asking you to be in this study because you are a woman between the ages of 25 to 65 who has a history of interpersonal violence that includes early childhood abuse and neglect. You are also an active consumer of the Mass. Rehabilitation Commission and currently receiving mental health counseling.

Why are you doing this research study?

The purpose of this study is to explore what is helpful to the return to work for women trauma survivors. Your participation will help to inform vocational rehabilitation and mental health counselors and the field of psychology to identify factors helpful to the return to work for women trauma survivors.

What will I be asked to do?

If you decide to take part in this study, I will ask you to participate in an approximately one hour interview. The interview will be audio taped for the purpose of reviewing the information. You will also be asked to fill out a short biographic information form. You may be asked to come for either a second interview in person or asked to speak with me by telephone to discuss topics covered during the interview.

Where will this take place and how much of my time will it take?

You will be interviewed in one of following locations: MRC area office, local educational institutions, public libraries and/or community centers. The interview will take about one hour. The biographic should take about ten minutes to fill out.

Will there be any risk or discomfort to me?

If at any time during the interview you experience distress or discomfort, the interview will be stopped without negative consequences to you. If you want to quit the interview will be stopped immediately, and if you request, contact with your counselor will be facilitated.

Will I benefit by being in this research?

Your participation in the interview may help you gain additional insights related to your vocational rehabilitation from answering and sharing your experiences with me. The information learned from this study may help identify important factors women trauma survivors find helpful to the return to work.

Who will see the information about me?

Your confidentiality will be protected at all times. Your participation in this project will in no way effect services received at Mass Rehab Commission. Other than the initial referral from vocational rehabilitation counselor there will be no further communication between myself and your vocational rehabilitation and mental health counselors. Only the dissertation committee which includes a hired transcriptionist will see and/or hear information about you. No reports or publications will use information that can identify you in any way. Reported results of this research will change identifying information for the purpose of maintaining confidentiality. The recorded information and transcripts will be reviewed by the dissertation committee as a part of this research. Once the data generated from the interviews is analyzed the transcriptions generated from audiotape and other sensitive information will be destroyed.

Can I stop my participation in this study?

Your participation in this research is completely voluntary. You do not have to participate if you do not want to. Even if you begin the study, you may quit at any time. If you do decide to quit at any time you will not any right, benefits or services that you would otherwise have as an active consumer at MRC.

What will happen if I suffer any harm from this research?

No special arrangements will be made for compensation or for payment for treatment solely because of my participation in this research.

Who can I contact if I have questions or problems?

Your questions can be directed to Galina Gittens at (617) 776-2662 or to Dr. Mary Ballou at (617) 373-5937, anonymously, if you choose.

Who can I contact about my rights as a participant?

If you have any questions about your rights as a participant, you may contact Human Subject Research Protection, Division of Research Integrity, 413 Lake Hall, Northeastern University Boston, MA 02115 tel. (617) 373-7570. You may call anonymously if you wish.

Will I be paid for my participation?

You will be given \$25.00 in cash at the end of the interview.

Will it cost me anything to participate?

You may incur travel costs getting to and from the interview site.

I have read the consent form and my questions have been answered. My signature on this form means that I understand the information and I agree to participate in this study. I will receive a copy of this form.

 Signature

 Date

 Printed Name

 Galina E. Gittens M.Ed., CRC. CAGS.

 Date

APPENDIX F

BIOGRAPHICAL INFORMATION

Age: ____

Employment status:

- (1) full-time (2) part-time (3) occasional (4) disability SSDI/SSI
 (5) no income (6) not employed: Student
 (7) not employed: Trainee, Intern, Volunteer

Level of Education (Circle one):

(1) completed grammar school (2) high school diploma or high school equivalency certificate (3) (4) post secondary education, no degree (5) Associated Degree or Vocational/Technical Certification (6) Bachelor's Degree (7) Master's Degree or Higher

Marital/relationship status:

- (1) single (2) separated/divorced (3) widowed
 (4) married/living with a partner (5) partnered but not currently living together

Children

Yes	No	If yes, How many?	Ages?
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Ethnicity (check all that apply):

- (1) African American / Black
 (2) Caribbean / Haitian
 (3) African
 (4) Asian American
 (5) Asian / Pacific-Islander
 (6) White / European American / Caucasian
 (7) European
 (8) Hispanic American / Hispanic
 (9) Native American / American Indian
 (10) Other _____