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ADVERSE LIFE EXPERIENCES AND MENTAL HEALTH OUTCOMES: AN ASSESSMENT OF CASE VIGNETTES.

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ABSTRACT
Adverse life experiences like trauma, loss, abuse, and ongoing stress play a major role in shaping our mental health. This paper explores the complex ways these experiences affect individuals by looking at real-life case examples. Drawing from existing research, it shows how our biological makeup, psychological state, and social environment all interact to influence how we respond to difficulties. Using these cases, the paper examines important theories about risk and stress to better understand why people's mental health paths can vary so much after tough times. By combining clinical knowledge with theory, it emphasizes the importance of personalized and context-aware approaches in assessing and supporting mental health. Based on the stories shared by clients in this study, the paper calls for a deeper, more comprehensive understanding of adversity, one that focuses on early recognition, coping strategies, and timely treatment, to improve both clinical care and mental health policies.

Keywords: *Adversity, mental health, case vignettes.*

INTRODUCTION
Exposure to adversities in the course of life's journey is traditionally associated with impaired mental health of individuals later in life, as established by studies over the years. This is evidenced in Holmes and Rahe's stress scale developed in 1967 to measure adverse life events such as grieving the death or illness of a family member or friend, dissolution of marriage, significant changes in life such as changes in work, social life, residence, migration, or relocation to a new environment or outstanding personal achievement which opened the way for the proper documentation of adverse life experiences resulting in negative mental health outcomes. Other unfavorable events, such as traumatic life experiences of all sorts, are also attributed to having mental health implications (Liu et al., 2015).

There is hardly a universal or standard definition for adverse life experiences, different people describe adverse life experiences in ways suitable to them. some synonyms are, however, common in their descriptions, such as "stressful, unfavorable, overwhelming, traumatic, threatening" among other words. Bateson et al. (2011) described ALE as "specific events that increase an individual's vulnerability to the occurrence of potential threats". Similarly, the Australian Psychological Society (2019) described ALE as a series of actual or perceived events that pose threats to the psychological or physical safety of an individual, their significant others, or the people around them. They are cumulative events that happen across an individual's life course that have a significant implication on their psychological well-being later in life (Richardson et al., 2018; Carstensen et al., 2020). By implication, adverse life experiences are perceived or actual cumulative individual life experiences that are stressful and overwhelming and capable of impairing the individual's psychological health.

As already established, research over the years has implicated adverse life experiences as a major risk factor for different mental health conditions including depressive disorders, anxiety disorders, substance use disorders, and psychosis, among other mental health problems. To buttress that, the stress vulnerability models posit that vulnerability to unfavorable life experiences is largely a greater factor determining the development of depression, anxiety, psychosis and functional disorders. (Mayo et al., 2017; Turner & Lloyd, 1995). Again, Miloyan et al. (2018) suggested clearly that adverse life experiences play a role in the emergence of anxiety disorders. Exposure to negative childhood experiences aside from general lifetime adverse events is also an established vulnerability to mental and psychological problems. Huang (2021) described adverse childhood experiences (ACEs) as "potentially stressful events that children experience

before the age of 18 years old". Oladeji et al. (2010) opined that adverse childhood experiences featuring violence in the family, parental mental illness and criminality, exposure to substance abuse have a great impact on the development of mental health problems later in life. Other childhood traumatic experiences such as the death of a parent or significant other, and exposure to harsh social and economic conditions, child abuse and neglect, family dysfunctions which lead to poor psychological well-being in adulthood independently or cumulatively has mental health consequences (Mosley-Johnson et al., 2019; Nurius et al., 2015 & Zhang et al., 2020).

Below are case vignettes showing the consequences of adverse life/childhood experiences on mental health outcomes later in life.

CASE VIGNETES SHOWING ADVERSE LIFE EXPERIENCES.

Case 1.

Unima (real name withheld) is a 32-year-old single male law enforcement officer.

He presents with the complaints of panic attacks characterized by shortness of breath and rapid heart rate. He also complained of poor sleep, and morning headaches ache all of a month's duration. His background history revealed that Aminu is from a polygamous family setting of three wives and 17 children. He is the eldest of his mother's children. Growing up, he experienced a lot of family dynamics, ranging from constant quarrels among his father's wives and siblings, competition on the available resources, including food and other needs. He could not be sponsored in school full-time by his parents, as a result, he dropped out in primary 4 because they could not afford his education. owing to this, he was sent to an Islamic cleric (mallam) alongside many of his father's children to acquire Islamic education. There, he lamented that they worked long hours on the farm and in the end, would not feed well. He later went back to Western education when he was already much older. There is a positive history of psychoactive substance use as his siblings abuse them. He, however, denied the use of psychoactive substances of any kind as he said his religious orientation does not permit him to do so.

Unima, who was transferred to a new environment to continue his work, lamented about the stressful nature of his new place of work. some of the complaints were about inconvenient accommodation, transportation, and the high volume of people he needed to attend to in just one day, saying the instances made work very stressful for him.

Growing up, at about the age of 13, he used to have an infection on his skin which persisted until adulthood despite treatments. This persistent skin rash left him with bumps on his chest, which he is not comfortable with. he was abused when he was about 12 years old by a 22-year-old woman who invited him to her room and asked him to touch her private part and fondle her breast. In the process, she asked him to penetrate her when someone interrupted them, and the woman asked him to quickly dress up and leave and never invited him again but continued to cater for his needs henceforth. He indicated that after that experience, he developed an interest in women and was curious to make love soon but was disappointed when the lady didn't invite him again. This he said happened when he was in Islamic school and away from his parents. He reported that he had his first girlfriend in JSS one. He tried to make love to her as he recalled that he took her to the house where he lived with his uncle. after foreplay, just when he was about to penetrate her, someone again interrupted them and the lady left immediately. Patient indicated that when his girlfriend left, he was already aroused and ready to have sex he decided to masturbate to relieve himself of his urges. Again, while in a public function, he started foreplay with his girlfriend and became aroused but could not have sex with her because of the nature of the place. He further indicated that after several failed attempts to have sexual intercourse, he became deeply distressed and was no longer keen about penetrating a woman again. He, thereafter, discovered that he could get sexual satisfaction without necessarily meeting a woman which further reinforced his masturbating behavior. While he continued to masturbate, he discovered that he lost interest in women and stopped any attempt to make intimate relationships with women.

He, however, noticed that as he was growing older, his level of sexual desire became stronger but he could not befriend a woman because of previous disappointments as regards sexual intercourse. He also learnt from his friends who were always boasting about how many rounds they had with ladies before ejaculation that he was having early ejaculation due to constant masturbation. This made him feel that he was not man enough to satisfy a woman, nor sleep with her for long, and did not want to disgrace himself before women. That pushed him further away from women. Also, he indicated that he went to check the internet at the school's library and confirm his fears that he was not man enough to satisfy a woman due to the early ejaculation he was having as a result of prolonged masturbation. He developed more strategies to run away from women in order not to disgrace himself. He currently has a fiancée whom he has been dating for about 5 years but has not had sexual intercourse with her because of the fear that he may not be able to satisfy her. Although they've been engaging in foreplay, he keeps telling her that she should wait until after their marriage before they can have sexual intercourse. He still masturbates occasionally when sexual desire is intense

Case 2.

Mr. I.B presented in our facility in company of his uncle and his colleague at work with the complaints of using alcohol of 3 years duration, smoking cigarette of 2 years duration, undue suspicion of 1 year 2 months duration as he would always accuse relatives of spying on him, unusual behavior of 10 months duration as he was seen roaming about aimlessness, and would wear cloths in the wrong side, excessive speech of 6 weeks duration before presentation. He started using alcohol to cope with challenges in his workplace and "to enable him think like a man". He continued with more bottles to help him cope with stress and feel good and energized to carry out his daily routines. He started smoking cigarettes two years later "to find out what smokers enjoy. He decided to continue with the use of cigarettes because it keeps him warm. He reports he takes 6 to 7 sticks per day depending on the weather. The cigarette makes him feel good and better able to cope with the daily stressors in his workplace.

He was observed to be behaving in an unusual way at work. He was noticed to be sleeping in the office and would not go home. His behavior became strange as he was withdrawn from his colleagues and was unduly suspicious. His uncle reported that he was making allegations about his boss that he wanted to harm him and was looking for his downfall by requesting that he goes for psychiatric evaluation. Patient who later resigned his job to travel to china for his PhD was later deported on grounds of unstable mental health. He thereafter relocated to Jos and was unreachable for a about three months. There, he was noticed to be talking excessively jumping from one theme to another unrelated one. Sometimes, his speech was irrelevant, does not make meaning to anyone, neither could one make meaning from what was said. His uncle and one of his colleagues therefore decided to bring him to the hospital for expert management. He is currently being managed as a paranoid schizophrenia case.

Patient's parents were separated on grounds of infidelity from his father when he was about 9 years. He described their relationship as 'not cordial and unfortunate' as he said they had chaotic interaction; they often engaged in fights and quarrels which made him sad as a child. During the period of the separation, the children from his parents were distributed to other family members. He claimed he was "dumped" with his paternal grandmother for the 5 years of their separation. He is the first of three children from his parents. He does not have a cordial relationship with his siblings, because he believes they always betray him.

He perceives his father as a drunk and a cheat, he perceives his mother as a hardworking woman who worked very hard to cater for her children's needs. There is a positive history of substance abuse in his family, his father also takes alcohol. There is no history of psychiatric illness in the family.

During his later childhood, his material and emotional needs were not adequately met because of his father's irresponsibility because of "his infidelity and rude attitude". During the 5 years

separation, he indicated things were quite difficult for him and his siblings because they were staying with different family members. He was with his paternal grandmother who had many other kids with her but had limited resources to cater for them. He claimed food was dished in a tray and every child had to struggle to get out of it. There was no possibility of eating to one's satisfaction as it was basically the case of 'survival of the fittest'
At school, He described his relationship with his teachers as not cordial as he complained that his teachers often created fear in him by shouting at him at the slightest mistake. His relationship with his classmates was also not cordial; he said he did not trust anyone to make him a friend. He was admitted into the University to study medicine and surgery. However, after the first year he was unable to meet the qualification requirements, he was transferred to another course to continue the same year. He ascribed his failure to his father's neglect and his inability to live up to his responsibility as a father. He claimed his father was not supportive; therefore, he had to work to cater for himself and support his mother with his tuition. He recalled he would go to a construction company to do menial labor after his lectures and had little or no time to attend to his studies. He stated that he also had some carryovers during his program, but he was able to get over them and he graduated.

He had not been able to sustain any relationship but looked for a girlfriend whenever he wanted to satisfy his sexual urges. When he can't find one, he engages in masturbation. He believes marriage is not healthy and would rather remain single than commit himself in marriage with anyone. He indicated that his earlier experiences with his parents' ugly marriage made him detest marriage. His two children live with his then girlfriend but claimed he also contributes to their upkeep.

THEORETICAL FRAMEWORK

This study utilizes the cumulative risk theory and stress progress model to aid understanding of the variables and the concepts of the study.

Cumulative Risk Theory

Cumulative Risk Theory, first proposed by Rutter in 1979 and further developed by Sameroff and colleagues in the 1980s, explains how adverse life experiences impact mental health. Rather than a single risk factor causing harm, it is the accumulation of multiple risks, such as poverty, family conflict, abuse, or neglect, which increases the likelihood of negative mental health outcomes in a dose-response relationship. The theory emphasizes that the total burden of risk factors is more predictive of mental health problems than any isolated factor. Exposure to multiple adversities overwhelms coping resources and disrupts development, increasing vulnerability to disorders like depression, anxiety, and behavioral issues. Clinically, Cumulative Risk Theory encourages a holistic assessment of an individual's life context, considering the number, severity, and duration of risks rather than focusing solely on isolated events. This comprehensive perspective explains why some individuals with multiple adversities experience poorer outcomes and need more integrated intervention strategies.

Relationship Between Cumulative Risk Theory, Substance Abuse, and Mental Health

Cumulative Risk Theory clarifies that substance abuse and mental health disorders often result from the accumulation of multiple stressors over time, not a single cause. For example, an individual facing family conflict, financial hardship, and social isolation encounters several risks that collectively increase vulnerability to substance abuse and mental health challenges such as anxiety or depression. Substance abuse may develop as a coping mechanism to manage overwhelming stress from these multiple risks. However, substance abuse can also exacerbate

mental health problems, creating a compounding cycle of risk. The presence of trauma, poor social support, and economic instability further heightens the likelihood of co-occurring substance use and mental health disorders. This theory points out the importance of holistic treatment approaches that address the full spectrum of a person's life circumstances instead of focusing narrowly on symptoms. Understanding how risks accumulate and interact enables more effective interventions targeting both underlying stressors and their manifestations.
To conclude, cumulative Risk Theory helps clinicians recognize how multiple life challenges increase the risk of substance abuse and mental health difficulties, underscoring the need for comprehensive, person-centered care.

Stress Process Model
Developed by sociologist Leonard Pearlin and colleagues in the 1980s, the Stress Process Model tenders a comprehensive framework for understanding how stress originates, evolves, and impacts individuals over time. This model explains that stress is not simply caused by external events but arises from the dynamic interaction between individuals and their environments. Key to the model are two psychological mechanisms: cognitive appraisal and coping strategies. Cognitive appraisal is the individual's subjective evaluation of an event, whether it is seen as threatening, manageable, or irrelevant. This perception shapes the intensity of the stress experienced and influences emotional and psychological responses. Thus, the same event can be experienced very differently by different people depending on how they interpret it. Coping strategies refer to the behavioral and mental efforts individuals use to handle stress. These can be adaptive (such as problem-solving and seeking social support) or maladaptive (like avoidance or substance use), and they critically affect the outcomes of stress exposure.
The model also incorporates broader social and structural factors, such as socioeconomic status, social support networks, and chronic role strains, that shape both the likelihood of encountering stressors and the resources available to cope with them. When stressors accumulate, especially alongside limited coping abilities and insufficient support, they can lead to significant mental and physical health problems.
By conceptualizing stress as a process rather than a fixed reaction to isolated events, the Stress Process Model provides a clear explanation of how life circumstances, personal resources, and social context interact to influence individual well-being.

Relationship Between Stress Process Model, Substance Abuse, and Mental Health.
The Stress Process Model helps in the understanding of the complex relationship between stress, mental health, and substance abuse in simple terms. It shows that stress isn't just about the tough events people face, but about how those events are experienced and handled over time. When someone goes through difficult or adverse life experiences like trauma, loss, financial struggles, or ongoing hardships, they don't all react the same way. How they interpret these challenges, through what the model calls *cognitive appraisal*, plays a huge role. For some, an event might feel overwhelming and threatening, while others might see it as something manageable or temporary. This perception shapes their emotional and mental response. Then comes the way people cope with these stresses. Some find healthy ways to handle their feelings, like talking to friends, problem-solving, or seeking professional help. But others might turn to substances, like alcohol or drugs, to numb the pain or escape the weight of their stress. Unfortunately, while substance use might offer short-term relief, it can also lead to deeper problems, intensifying feelings of anxiety, depression, or despair.
The model also points to the fact that stress and coping don't happen in isolation. Our social environment, our relationships, economic status, and community support, can either provide strength or add to our burden. When someone faces multiple stressors with little support or few healthy coping options, the risk of developing both mental health issues and substance abuse

problems increases significantly. In essence, the Stress Process Model paints a picture of how intertwined our life experiences, emotions, and behaviors are. It shows that substance abuse and mental health challenges often stem from the same source: the ongoing struggle to manage stress in a world that sometimes feels overwhelming. Recognizing this interconnectedness helps us approach treatment with compassion and a broader perspective, focusing not just on symptoms but on the whole person, their experiences, their coping strengths, and their support systems.

By understanding stress as a continuous process shaped by perception, coping, and social context, this model encourages individuals to look beyond quick fixes. It inspires more empathetic, holistic care that addresses both the root causes of suffering and the ways people try to survive and heal.

Conclusion

As shown by the theories, case vignettes, and literature reviewed in this study, exposure to multiple life adversities, if not recognized and addressed promptly, can increase the risk of severe mental health challenges. While it may be impossible to avoid adversity altogether, it is crucial for individuals facing difficult situations to seek help early. Early intervention can help prevent mental health crises and support a healthier, more resilient life.

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