TRAUMA MATTERS

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An electronic version of the Trauma Matters Newsletter is available at:
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Supporting Healthy Sexuality for Women in Treatment and Recovery

Women with sexual trauma histories, child sexual abuse, and adult sexual violations are at significant risk for substance abuse, addiction, mental-health disorders, recurrent violent interpersonal relationships, chronic physical health conditions, and poverty. A woman who has experienced sexual trauma lives a life of desperation, often fighting for her survival. If the traumatized woman has developed an addiction to drugs and/or alcohol, she may turn to prostitution to maintain her addiction. Subsequently, she can become vulnerable to incarceration and repeated traumatization. Consumed by her need to forget past events, the addicted woman lives only for the next "high" she views as essential to her survival. Through intervention by family, children's services, or the criminal courts, and often not of her own will, she enters treatment. The abused woman all too often continues to recreate the cycle of despair, sabotaging all efforts to assist her in changing the course of her life.

Elizabeth, also known as Liz, is a case study of someone deeply affected by sexual trauma. Sexually abused by her father from age three until she left home for college, Liz was never protected from exploitation and trauma. She coped through perfectionism in school and sports; always keeping up the front that was modeled at home. *All is well and right in the Richardsons' family* was the mantra she maintained as the focus for her survival. Once Elizabeth left home to attend college, she thought she had left behind the well-kept secrets of her family life. While in college, she maintained a life of rigidity including a demanding, meticulous schedule of academics and athletics. In spite of being a straight "A" student, she harbored deep-seated anxiety, depression, and sadness only a survivor of sexual abuse would recognize. Her body became trapped in the bindings of untreated anorexia and bulimia, yet she continued to do everything in her power to wear the mask of normalcy.

Eventually, her internal world of violation penetrated her ability to keep up a front. Liz drank without regard, sought out pills, and then heroin, to numb out terrifying feelings she had been working so hard to suppress. As Elizabeth's world spiraled out of control she engaged in abusive relationships that mirrored the rage she knew as a child. Liz dropped out of college and sought comfort from partners who violated her. At 21, she became pregnant, and gave birth to her daughter Anna who was immediately taken away from her by the family and children's court because Elizabeth had tested positive for opiates at the time of Anna's birth.

Elizabeth and other women like her who have been violated multiple times do not understand why their lives are so difficult. To survive the ravages of childhood requires numbing, dissociation, and a disbelief that those who were supposed to protect them could breach their trust and desecrate their bodies. Maladaptive attachments in the developing brains of young children and adolescents offer short-term survival and long-term consequences in unhealthy patterns of living and sexual intimacy.

Women like Liz have the right to healthy sexuality and intimacy and providers can develop strategies to assess women's sexual health capacity. Treatment centers that serve people with substance abuse are in a position to provide the "Elizabeths" of the world with a safe place to explore their experiences of sexual trauma, – and the drug and sexually linked triggers that can lead to the re-occurrence of substance abuse. Unfortunately, professionals in a position to help abused women frequently focus on sobriety and restrict dialogue on sexuality and intimacy that can be the underpinnings of substance abuse and relapse. Professionals that serve women affected by trauma and substance abuse in the criminal justice system, mental health/addiction services and family planning programs have consistently shared their uncertainty in talking about sexuality with sexually abused women. The reasons for this avoidance are many. Firstly, there is the high potential for incidence of vicarious trauma for therapists who are counseling women on sexual trauma. Many therapists may have their own history of sexual abuse that they may not have resolved. For these reasons, it is imperative that clinician self-care not be ignored while developing sexual recovery programs for women. Additionally, therapists have expressed their concern that discussing sexual trauma may result in overwhelming unmanageable distress for the woman who has been violated. Some therapists also fear that their training and skills are limited around sexuality. When these hesitations are compounded with unresolved personal or vicarious trauma, the challenges inherent in integrating sexuality as part of the treatment process are clear. Therefore, optimal supervision, ongoing peer support, training, and educational tools for therapists need to be part of the planning and implementation process for client sexual recovery. Ideally, from the first day of treatment, women could be provided information and a review of the agency's commitment to fostering healthy choices and rights regarding sexuality. A sexual recovery plan and psycho-educational programs can help provide woman ongoing tools and support toward achieving healthy intimacy with sobriety.

The curriculum, *Sanctuary for Change*, (Germayne Tizzano, Ph.D.), is tailored specifically to the sexual health needs of women with histories of trauma and abuse and/or who are victims of intimate partner violence. Based on the research of Dr. Albert Bandura, (1977), *Sanctuary for Change* focuses on building skills and positive expectations to help women make informed decisions regarding sexual health. The *Sanctuary* curriculum draws on the relational and cultural theory of Miller and Gilligan (1976), which posits that women are motivated to grow in relationships with others, and that these interpersonal connections can create a renewed sense of courage, strength, and self-worth. The *Sanctuary for Change* model is designed to help women with histories of abuse come together to safely acknowledge the detrimental impacts of their traumatic experiences on their ability to make sexually healthy choices. Through small group discussions, hands-on activities, and self-reflective tools, women develop an individualized program of recovery aimed at sexual health goals. Participants who have attended *Sanctuary for Change* have shared how enlightening and beneficial the program has been for them. Previous attendees report practicing healthy sexual choices, screening for HIV, talking with their counselor about their sexual preferences, being gentler to their bodies, and selecting partners who respect their choices. The *Sanctuary* program offers the chemically dependent woman an opportunity for a new set of values, beliefs, and practices regarding her own sexuality, introduced within the safe social context of the classroom. This opens the door so that she can discover the courage within to redefine who she is and commit to healthier sexual choices.

Submitted by Germayne Tizzano, Ph.D.

Ms. Tizzano will be presenting *The Prevention of Relapse: A Sexual Recovery Model for Women With Trauma and Substance Abuse Histories* at the Connecticut Women's Consortium on June 19th and 20th, 2014. For more information on Dr. Tizzano go to: www.viewsfromatreehouse.com

For a complete list of references for this article please visit: www.womensconsortium.org/references_Trauma_Matters.cfm

Ask the Expert: A Conversation with Francine Shapiro, Ph.D.

Francine Shapiro, Ph.D., is the originator and developer of Eye Movement Desensitization and Reprocessing (EMDR), which has been so well researched that it is now recommended as an effective treatment for trauma in the *Practice Guidelines* of the American Psychiatric Association, and by the Departments of Defense and Veterans Affairs. Dr. Shapiro is a Senior Research Fellow Emeritus at the Mental Research Institute in Palo Alto, California, Executive Director of the EMDR Institute in Watsonville, CA, and founder and President Emeritus of the EMDR Trauma Recovery Humanitarian Assistance Programs, a non-profit organization that coordinates disaster response and low fee trainings worldwide. She is a recipient of the *International Sigmund Freud Award* for distinguished contribution to psychotherapy presented by the City of Vienna in conjunction with the World Council, the American Psycho-

logical Association Trauma Division *Award for Outstanding Contributions to Practice in Trauma Psychology*, and the *Distinguished Scientific Achievement in Psychology Award* presented by the California Psychological Association. Dr. Shapiro was designated as one of the "Cadre of Experts" of the American Psychological Association & Canadian Psychological Association Joint Initiative on Ethno-Political Warfare, and has served as advisor to a wide variety of trauma treatment and outreach organizations and journals. She has written and co-authored more than 60 articles, chapters, and books about EMDR.

Q: Why did you enter the trauma treatment field?

A: After developing the procedures of EMDR therapy in 1987, I wanted to make sure it was properly tested. I decided to do a randomized study but first wanted to explore the therapy's applications with those having difficulties with old memories. That brought me to a veterans administration outreach center where I discovered all the suffering that had continued for veterans despite the Vietnam War having ended 10 years before. I discovered how often their suffering was born of their nobility: pain about those they hadn't saved or had harmed. I discovered that their decade-long pain and symptoms disappeared after only a few EMDR sessions. I have since devoted my life to the goal of providing this relief to all who need it.

Q: Can you tell us what you consider to be the most helpful stabilization skill or tool one can teach to a trauma survivor?

A: I believe that processing the disturbing trauma memories is the way to eliminate the suffering and allow people to feel good about themselves, enjoy life and bond appropriately with others. Until that happens, the memories will continue to be triggered and hamper them in their present life. In EMDR therapy we prepare clients for processing with self-control techniques that allow them to change their negative emotions, physical sensations and thoughts. The techniques are described in detail in my book *Getting Past Your Past.* Different clients need different techniques depending upon their particular complaints. However, the ones I've found helpful for many clients are skills that allow them to bring back a feeling of safety when they feel distressed. These are skills we can all use occasionally but we shouldn't be forced to use them all the time because of unprocessed memories.

Q: Can you tell us one thing you think all trauma-focused clinicians should know?

A: Therapy does not need to take a long time. Randomized studies with single-trauma victims have demonstrated that 4.5 hours of EMDR therapy results in 84-90% of them no longer have PTSD. In a Kaiser Permanente study, 100% no longer had PTSD after a mean of 5.4 hours of EMDR therapy. The studies demonstrated that the negative thoughts, feelings and emotions were still absent at follow-up. However, multiple traumas take longer to treat. For instance, in the same Kaiser study, 77% of multiple-trauma victims no longer had PTSD in the same time frame. More session are needed for comprehensive treatment. Focused EMDR therapy can accelerate the healing process. It is important to take a good history that identifies not only the major trauma needed to diagnose PTSD, but the full range of adverse life experiences that may be impairing the client. Research has indicated that general life experiences can cause even more PTSD symptoms than major trauma. Other research has demonstrated that negative childhood experiences are correlated with a wide range of both psychological and physical pathology. Comprehensive processing of these memories is needed. I suggest that all clinicians read this article: Shapiro, F. (2014). The role of eye movement desensitization & reprocessing (EMDR) therapy in medicine: Addressing the psychological and physical symptoms stemming from adverse life experiences. *The Permanente Journal, 18,* 71-77. It is available free as a PDF: http://www.thepermanentejournal.org/files/Winter2014/EyeMovementDesensitization.pdf

Submitted by Francine Shapiro, Ph.D. in conversation with Cheryl Kenn, LCSW

Trauma Histories and Prison-Victimization in Correctional Populations

This article is the third in a series examining trauma and trauma-related experiences among incarcerated individuals. This population is sometimes overlooked when it comes to assessing and treating trauma either upon initial contact with the prison system or post-release. This series primarily focuses on trauma in men within the prison system. Nationwide men comprise 91.3% of incarcerated individuals.

The incarceration rate in the United States is by far the highest in the world (see *Trauma Matters*, Fall 2013). According to a recent report by the National Research Council of the National Academy of Sciences (2014), "with

less than 5% of the world's population but nearly 25% of the world's prisoners, the U.S. continues to rank first among nations in both prison and jail population and per capita rates" (p.2). Following a review of the relevant research, Wolff, Shi, and Siegel (2009) identified health as one of the overlooked ways in which people inside prison are different from people without incarceration histories, despite increasing attention paid to this disparity over the past 12 years. Based on their review, incarcerated people have higher rates of some chronic and infectious diseases (e.g., HIV/AIDS, hepatitis C, heart disease) and behavioral disorders (e.g., substance abuse disorders, depression, schizophrenia, posttraumatic stress disorder). In addition, they also identified another disparity receiving growing attention: the elevated rates of victimization both before and during incarceration (Wolff et al., 2009).

Reviewing the literature, Miller and Najavits (2012), found that both men and women in prison have histories of interpersonal violence. Although estimates vary considerably, at least half of incarcerated women have experienced at least one traumatic event in their lifetime. Based on their review, Miller and Najavits (2012) concluded that for female offenders, sexual violence, defined as the combined adult and child sexual abuse and assault, is by far the most commonly reported type traumatic experience, followed by intimate partner violence. For incarcerated women, rates of sexual victimization across the lifespan are highest in childhood. Rates of interpersonal violence reported by men are lower by comparison but nevertheless significant. Childhood abuse is reported by 6% to 24% of incarcerated men and by 25% to 50% of their female counterparts. Prior to age 18, physical abuse is more likely than sexual abuse for males but both occur at equal rates for females. Abuse in childhood is strongly correlated with adult victimization, substance abuse, and criminality for both genders. Wolff et al. (2009) underscored the continuation of victimization inside prison for many individuals, regardless of gender. Evidence shows that rates of victimization are higher in prison settings than in the general community. Violent victimization rates, inclusive of robbery and sexual and physical assault, are estimated at approximately 21 per 1,000 (0.021%) in the community (Bureau of Justice, 2006). Rates of victimization for the incarcerated population are considerably higher though the rates vary. Using a sample of 581 male inmates drawn from three Ohio prisons, Wooldredge (1998) found that approximately 1 in 10 inmates reported being physically assaulted in the previous 6 months, while 1 in 5 inmates reported being a victim of theft during that same time frame. Aggregating all crimes, 1 of every 2 inmates surveyed reported being a victim of crime in the previous 6 months. More recently, Wolff, Blitz, Shi, Siegel, and Bachman (2007), based on a sample of more than 7,000 inmates, reported 6-month inmate-on-inmate physical victimization rates at 21% for both female and male inmates–a rate 10 times higher than the overall victimization rate in the community.

Somewhat surprisingly, however, Miller and Najavits (2012) stated that women ("especially those who were homeless, drug addicted or living with dangerous partners prior to incarceration) were statistically safer from some forms of victimization in prison than they were prior to incarceration. For example, the estimated prevalence of sexual assault in US prisons, based on the most recent Bureau of Justice Statistics inmate survey, is about 4.4% (as cited in Beck & Harrison, 2010). Yet, for women on college campuses, the estimated prevalence of sexual assault is from 20-25% (Bureau of Justice Statistics, 2009; Youth Violence and Suicide Prevention, 2004). Studies have also shown that incarcerated women with posttraumatic stress disorder (PTSD), report a much higher rate of witnessing violence than the female population in general and that many of them designate such witnessing as their most serious trauma. Miller and Najavits (2012) go on to cite Loper (2002), who indicated some women express a feeling of safety and relief during intake at women's prisons. Blackburn, Mullings, and Marquart (2008) suggested that escaping homelessness, sex work, violent partners, dealers, and pimps may contribute to a new awareness of the level of danger with which they have lived. It is possible entry to incarceration provides a measure of safety that allows women to identify their trauma symptoms and triggers. For incarcerated males, the picture is different. Based on their review, Miller and Najavits (2012) indicated that for male prisoners the most commonly reported trauma is witnessing someone being killed or seriously injured followed by physical assault and childhood sexual abuse (the rate of childhood sexual abuse is much higher than in the general male population). Overall, higher rates of trauma and earlier age of trauma onset is associated with increased violence and victimization in prison.

Unlike women, men are rarely safer behind prison walls than prior to incarceration. Their risk of sexual assault increases exponentially when they enter prison, compared to the risk for males in the general population (National PREA Commission, 2009). Male prisoners face an increased threat of lethal violence in male facilities that may trigger more externalizing trauma responses (i.e., aggression directed outwards) and high levels of arousal that can endanger staff and other inmates (Freedman & Hemenway, 2005). Trauma-informed correctional systems may be a means of increasing prison safety, enhancing prisoner rehabilitation, and potentially reducing recidivism rates. The good news: trauma-informed correctional care does exist and is receiving increased attention nationwide. A look at progress in integration and adoption of trauma-informed care by state departments of correction is the subject of the next article in this series.

Submitted by Steve Bistran, MA

For a complete list of references for this article please visit: www.womensconsortium.org/references_Trauma_Matters.cfm

Collective Trauma and Community Resiliency: An Emotionally Charged Boston Marathon

A **collective trauma** is a traumatic psychological effect shared by a group of people of any size, up to and including an entire society. Traumatic events witnessed by an entire society can stir up collective sentiment, often resulting in a shift in that society's culture and mass actions. http://en.wikipedia.org/wiki/Collective_trauma

In just one year since the traumatic heart wrenching terrorism and collective trauma of the Boston Marathon tragedy, the world has watched as this same community has lifted itself and coalesced around a rallying cry of "Boston Strong." Different from personal inter-relational trauma, collective trauma and the resulting community conversation, has a virtually unavoidable rippling effect that persists and perpetuates through media and community forums. While an individual's values, beliefs and thoughts can be altered when they experience a traumatic event, a community's culture is similarly jarred and influenced both in that moment, and years into the future. **The following personal reflection illustrates the far reaching influence of collective trauma, even when an individual is not a direct witness to an event.**

Running holds enormous healing power for me. I build my day around my run. In the winter months, I pray for days above 20 degrees so I can run outdoors. The refreshing feeling of running outside and freeing my mind brings me peace. Mindful running allows me to prepare for being present in my day. Fifteen years ago, when I started running, I smoked cigarettes, was 40 pounds heavier, and in poor health. Making the choice to run instead of smoke was a life-changing event that I will always cherish. Running has brought physical, emotional, and spiritual benefits to my life. In 2012, I ran a Boston Marathon qualifier and beat my qualifying time by 9 minutes to qualify for the 2014 Boston Marathon. My family and I decided to make this a family event and we were all excited to plan the trip. On April 15, 2013, we watched the race on TV and tried to scout out places my family could wait to watch me finish the following year. What we saw as we watched people cross the finish line will forever stay in my mind and heart.

The extent to which runners push themselves to cross the finish line in a marathon is a product of immense sacrifice and dedication of time and effort in the months or years leading up to the race. A profound and palpable sense of satisfaction and accomplishment occurs when one crosses the finish line. This wonderful moment was stolen from many who ran the Boston Marathon in 2013 and for all who watched in horror.

Our sense of safety was taken from us, our lives were changed, and our world appeared scary. As a runner, it hurt me in another way. The bombing at the Boston Marathon threatens the one place in the world where I have consistently felt free and safe. Based on my times, if I had been running in the 2013 race, I most likely would have been crossing the finish line at the time of the explosions–my family standing nearby to catch a glimpse of me. I question whether I can ever again feel completely safe and free while running a race.

Would the experience of participating in races be infiltrated by a miasma of fear? Would registering for races involve thinking about losing my life? Was my peaceful world of running ruined? I cried with my family as we watched so many lives changed in a matter of minutes.

In the time since the bombing, I have witnessed increased police protection, new policies for bag checks, and new guidelines for spectators. Some races have prohibited spectators from congregating in the finish-line area. People cheering me on during the race, especially at the end, uplift me and give me strength. They give me strength. I have run several races since the Boston Marathon bombing and have gained healing strength after each one. As a community, runners have spent the last year rebuilding our safe place.

The healing power of running for me is so precious that I will always fight to keep its gifts in my life. Some days my run is a chore because of family, work, or training requirements. On those days, I try to remain grateful that I am still able to run. People lost that gift last year. Our lives are filled with choices about how to focus our energy. It can be easy to take quick fixes, but it is important to make the choice to heal with time and purpose. My process of healing through running will be with me for a long time, so I will invest the time and energy to keep it safe.

On April 21st, I ran the Boston Marathon. I ran the race to heal and get my free place back. I ran for all of the people and families who lost lives and limbs, for all the people who can no longer run because of last year, and for the running community. It was a gift to meet people who were running, cheering us on, and families who supported all of the people around the race. It was an honor for me to be able to run this year and I feel stronger than ever before.

Submitted by Linda Lentini, Advocacy Unlimited, Director of Recovery University

This article was originally published for Advocacy Unlimited's (AU), TOIVO CENTER blog. The TOIVO center is an intentional living space where people from all walks of life can engage in expert facilitated yoga, drum circles and meditation. TOIVO is part of AU's new multi-faceted initiative committed to maximizing human potential through deliberate action and strivings toward daily lives rich in texture and meaning. AU will host a conference at Central Connecticut State University on ***Saturday, June 28, 2014, "2014 Holistic Health Conference…Healing from Within."*** To learn more go to: www.toivocenter.org

Featured Resource
Staff Care: A Drop, a Seed, a Moment

I often hear, and have said myself, "I am planting a seed," or "I am one drop in someone's bucket," or "I am one stepping stone in someone's journey." In the helping professions, we use these phrases to remind ourselves that progress is often seen in the smallest measurement of change, but how often do we apply this to ourselves and our own self-care? It has been a long winter and a hectic spring as we catch up from the many snow cancellations and move into the end-of-the-fiscal-year budgets, annual reports, meetings, filling beds, and not to mention elements of our personal lives with graduations, weddings, prom season, and the to-do list goes on and on and on. With this long list of "all that must be done," there is a longing for a day off to do nothing, a leisure day to do something fun, a long vacation to recharge. These are all wonderful ways to replenish lagging energy, but if we wait to find large chunks of time to care for ourselves, we miss the opportunities in moments.

These moments (or seeds or drops or stepping stones) in self-care might look like this:

- I missed my yoga class this week, but you might find me doing a forward bend at the copy machine.
- I did not meditate for 20 minutes today, but I just took three deep breaths as I sat at my desk.
- I didn't find 30 minutes for the treadmill, but took a fast walk to the communal printer.
- The team meeting was canceled, but I connected with a colleague for a few minutes today and gave/received some much-needed moral support.
- My massage is not until next week, but I moved away from the computer, stood up, and stretched.
- Rather than criticizing myself, I downloaded a mindfulness moment app to my phone for inspirational reminders.

What is your moment?

Submitted by Eileen M. Russo, MA, LADC

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