Appendix 3
Suggested Reading for Chapter 3: The Effects of Trauma in Women's Lives

UNDERSTANDING TRAUMA*

In this topic you will learn about trauma and the feelings associated with it, and how you have learned to cope with trauma in your life. This is difficult work, and may bring up some strong emotions for you. You may not want to complete the whole chapter all at once. To help ease you into (and out of) this work, we'd like to first introduce you to a simple ritual. Each time you begin and end your work, use this ritual to keep yourself focused in the present and to remind yourself of the positive aspects of your life.

Beginning and Ending Ritual

Use this simple activity any time you are working on difficult issues. Some women like to complete this activity just prior to talking with a counselor, writing in a journal, visiting with a family member, doing some artwork related to trauma, or repeating an exercise from this book. First, write down four good things that happened to you in the last two days. They don't have to be big things-just things that made an impression on you and that were enjoyable. For instance, my list for the last two days is:

1. I saw a cute baby and she smiled at me.
2. I had a nice visit with an old friend.
3. I finished reading a heartwarming novel.
4. The sweater I put on this morning felt warm and cozy.

At the end of the session, write down two things you are looking forward to. One that is within the next few days and one in the more distant future. For example, my list would be:

1. Coming right up: buying a new kind of bread I really like at the grocery store.
2. In the future: spring-warm weather, flowers, and birds.

> The purpose of this ritual is to help you stay connected with the good things in your life while you are doing this work and also to put a frame around your work so it becomes a small part of your life with a beginning and an end, not your whole life.

To begin work on this topic, write four good things that happened to you in the last two days:

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Categorizing Your Traumas

Everyone experiences minor trauma-things that are temporarily upsetting and that may make us anxious and upset. Such things include:

- not getting an anticipated check on time,
- the car breaking down,
- missing an appointment,
- a friend being rude to you, or
- getting a cold.

Most of the time you probably get over these small traumas quickly. Below, list some minor traumas that you have experienced recently:

From time to time everyone experiences trauma that is harder to deal with and more upsetting: seeing a beloved pet hit by a car, losing a friend to a devastating illness, having your house broken into, getting divorced, or being a victim of a robbery. These experiences may cause an increase in anxiety and fears, insomnia, depression, nightmares, and flashbacks. As time goes on, the impact of these traumas tends to decrease until finally, while the person may still think of such traumas from time to time, day-to-day activities are not significantly affected.

List any of these kinds of trauma you have experienced in your life.

Unfortunately, people also experience trauma that is so horrific that it may seem almost impossible to overcome-trauma that is so awful that the symptoms persist and often overwhelm the person's life. Examples of these kinds of trauma include child abuse, sexual abuse, physical abuse, emotional abuse, being a victim of a violent crime, losing one or several close family members, or living through a war. Sometimes right after the trauma occurs, and sometimes much later, people who experience these kinds of trauma develop severe and persistent symptoms such as depression, anxiety, rage, nightmares, flashbacks, and feeling out of touch with reality. They may turn to alcohol, illegal drugs, promiscuous sex, or self-harming behaviors to try to ease the pain.

Little notice was taken of the effects of trauma, or the relationship between traumatic experiences and these kinds of symptoms, until after World War II and, more recently, the Vietnam War. In fact, people who experienced severe war trauma were (and still are) often told that they had a mental illness. After World War II, some soldiers and survivors of the Nazi concentration camps displayed serious and persistent symptoms that demanded attention. Similarly, during the Vietnam War, veterans returned from the battlefield with symptoms so serious and so obviously related to their war experiences that the effects of trauma could not be ignored. In recent years, the effects of other kinds of horrific trauma have also been recognized-yet much of the literature about trauma still reflects what we learned from soldiers, especially prisoners of war, and holocaust survivors.

We know that relieving the effects of trauma on a person's life takes very specialized treatment along with lots of persistence and courage. Activities such as the ones in this book can help you regain a sense of your power, validate your experiences, help you regain your sense of self so you can enjoy life, and relearn how to connect with others in meaningful ways.

What kinds of severe trauma have you experienced?

Factors That Affect Recovery and Healing

Every person responds to trauma in his or her life differently. There is no set period of time for recovery. The factors that seem to affect how long it takes to get over the effects of trauma in one's life—or at least reduce these effects so they are not controlling the person's life—include:

- personality type;
- the environment you grew up in—was it hectic and chaotic, or calm and peaceful;
- your current living circumstances;
- your general health;
- substance abuse or addictions;
- the length of your exposure to the trauma;
- the number of traumas you have experienced—even minor traumas; and
- the severity of the trauma.

No one else can determine how a trauma could or should affect someone else; do not feel that your trauma was "too small" to have had such a powerful impact.

One woman told us that she grew up in a hectic and chaotic household—small traumas were happening all the time, such as burned dinners, people yelling at each other, lots of people moving in and out. Some traumas that were harder to deal with were also happening simultaneously—she lost her favorite pet and she was involved in a serious car accident. These factors all combined to make it harder for her to deal with a serious sexual assault when she was a teen.

What factors in your life do you feel affect your healing journey?

Sharing Feelings and Experiences

List five words that you often use to describe how you feel.

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For many people, talking about the trauma helps—it's part of the healing process. You may be uncomfortable or not used to talking about it, but the inability to talk about feelings and the hard things that happen to us in our lives can make the healing process more difficult. In many families, people don't talk about trauma at all. There are a couple of reasons for this. First, family members may feel it is best to forget the bad things that have happened.

When Charlene was a little girl, her friend was killed in a very bad accident while she was playing with Charlene. Charlene's family felt it was best for her not to talk about the accident and they tried to get her to focus her attention on other things so she would forget. Charlene never forgot. As an adult she spent many years in counseling to relieve the effects of this trauma.

Many schools now offer children special programs and services when there has been a tragedy in the community to give students the opportunity to talk about the trauma and begin to heal.

A second reason for silence in families is that the family members don't want other people to find out about bad things that are happening, especially if it involves abuse. It becomes a family secret—a secret that protects the abuser and allows the abuse to go on. Family members may even be threatened to keep them from telling others what is happening, or there may be an unspoken rule in the family not to talk to anyone about certain things.

How did your family talk about feelings and other experiences?

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It helps to think about the words associated with these experiences so you can think more clearly about them, write about them, and tell supportive people what happened to you.

In this exercise, you will write some words that could be used to describe feelings related to trauma. To help you think more clearly about the feelings associated with the word, think of a color that matches that feeling you are describing. (You can use the same color over and over if that feels right to you.) For example, "angry-bright red," "isolated-dark gray."

Now make a list of ten "feeling" words that describe the trauma you experienced.

How did it feel to write and think about these words?

Coping with Trauma

When you were traumatized, especially if you were traumatized repeatedly, you figured out some ways to cope with the trauma so you could get by and still go to school, do your homework, find some peace and quiet for yourself, play, and so on without feeling the pain so much. This took a lot of strength and creativity.

One woman found some special places in the woods near her home. She called these places "camps" and spent a lot of time there reading books, playing with her

dolls, day-dreaming, and watching the clouds through the treetops. She felt safe and comfortable there because nobody could find her.

Describe some ways that you learned to cope with abuse in your life.

Repeat several times, out loud if possible, "I am a strong and creative person. I used these attributes to help me get through the hard times in my life."

Ending Ritual

Describe something you are looking forward to that will happen soon.

Describe something you are looking forward to that is happening in the more distant future.

Optional Activities

1. Glance at the headlines in your local paper. How do you think the people in these stories might have been affected by what happened to them? Do you think these things will be easy or hard for them to "get over"?
2. Begin talking about trauma. Briefly talk to someone you trust about your trauma—a sentence or two would be fine.

   How did that feel?

Things to Remember Every Day

- I can talk about feelings related to trauma if I wish. Talking to others about bad things that have happened to me helps me heal.
- I am a strong and creative person—I was able to develop some ways to cope with trauma that helped me at that time. I am proud of my strength and creativity.

THE BODY REMEMBERS WHAT THE MIND FORGETS*

Beginning Ritual:

To begin work on this topic, write four good things that happened to you in the last two days:

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Body Memories

Usually, when we are asked about a memory most of us assume that we must search for a story of some sort. We might try to conjure up a visual image of something that happened or a place where we spent time. Thoughts, words, and images do constitute our memories, but not entirely. We also remember things in other ways, such as through sound, smell, and taste. Sometimes the smell will be all we remember—the context is lost but the smell remains.

Our bodies also have memories. A feeling, an ache, an itch—these are physical sensations, but they can also be memories. Just as our intellects remember in words, our bodies' memories are stored in sensations. That pain in your back may be because you got too much exercise, or it may be a memory of something that happened a long time ago. In some cases, there will be other memories that accompany the pain, but in other cases the pain itself will be the only memory you have.

When you were traumatized, your body responded to this severe stress by trying to protect itself. It secreted hormones and other substances that may have given you some of the strength it took to endure what you went through. But with severe and repeated trauma, the body forgets how to shut this release off. You may feel tense, irritable, anxious, and nervous all or most of the time. When this goes on for a long period of time, you develop chronic tension and pain in various parts of your body—sometimes in the part of your body that was most affected by the trauma.

You may have so much pain that you try to ignore it. You may feel that you are really out of touch with your body and how it feels, or perhaps the discomfort and pain is so persistent that it keeps you from doing the things you want to do. With consistent use of some of the relaxation and stress-reduction exercises in this topic, you will notice that your body starts feeling better and better.

Patsy, a thirty-year-old stockbroker, felt that her body was always very tense and tight. She assumed this was normal. However, when she started getting aches and pains in her neck, shoulders, and lower back, she sought help. She began getting massages from a physical therapist, and noticed that each time she received one, her body felt more loose, flexible, and comfortable. The physical therapist explained to her the connection between the tension in her body and the trauma she experienced as a child. She now uses stress-reduction exercises she learned from the physical therapist to continue to release the tension she has held in her body for so many years.

This topic contains several exercises that, if used regularly, will gradually help you relieve the tension in your body. Most people notice they feel much better each time they do a relaxation and stress-reduction exercise. Occasionally people report that while engaging in a relaxation exercise they suddenly feel overwhelmed by very uncomfortable feelings in their bodies. If this happens to you, open your eyes right away and stare at something that you really like to look at (a book, a plate, a pet, and so on) for several moments until the uncomfortable feelings go away. If this happens to you often, you could keep your collection near or in the place where you do these exercises so you can look at them when these feelings come up, and when you feel better you can either return to the exercise or leave the work until another time. (Don't forget to do your closing ritual before leaving your work for the day!)

Repeat the exercises in this chapter that feel good to you as often as possible—make them an important part of your life.

Body Scan

Read this exercise before you do it and then do it from memory—trying to read it as you are doing it will be too distracting.

Relax comfortably in a chair or lie down—whichever feels better to you. Loosen any tight clothing. Take three deep breaths. Notice how your body feels in the space it is in. Notice how your body feels as it comes in contact with the chair, or the floor or ground. Notice how your clothes feel on your body. Now pretend you have a searchlight. Use that searchlight to search inside your body to find places that feel relaxed. Spend a few moments focusing on each of these places. Next, use the searchlight to find places where your body feels tense or uncomfortable. Spend a few moments focusing on each of these places.

Where in your body did you feel comfortable and relaxed?

Where did you feel tense?

Why do you think you feel tense and uncomfortable in this part of your body? Do you feel it has to do with something that is going on now, such as stress at work or carrying a heavy object, or do you think it has to do with something that happened in your past?

You may have had this tension or discomfort in your body for many years. It may have affected the way you sit, stand, and walk.

One woman noticed that she had a lot of tension in the upper part of her chest. Sometimes the pain became quite sharp and debilitating and she actually needed to hunch over to relieve it. Medical testing didn't show any problem. She remembered that the pain in her chest began when she was very young, when she felt afraid of the older boy in her neighborhood who frightened and hurt her.

You may not know why these places in your body feel the way they do. Fortunately, it is not necessary to know where the tension came from in order to release it.

Now that you have identified the places in your body that need help, try the exercises that follow. With practice, your body will begin to change the way it responds to the things that happen (and happened) to you.

Tension Releasing

Again, read the exercise before you begin, then put the book aside. This should take about five minutes. Play soft music in the background if you wish.

Choose one of the problem areas of your body to focus on. Explore that part of your body in detail with your mind. Ask yourself, "What are the sensations in this part of my body? How does it move?" Let this part of your body relax completely. Using your mind, imagine softness and warm light flowing into this part of your body.

How did you feel before you did this exercise?

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How did you feel after you did this exercise?

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Repeat this exercise as often as possible, focusing one at a time on each part of your body that is tense and uncomfortable. Do this exercise whenever you have a few free moments—before you go to sleep at night, if you awaken and have a hard time getting back to sleep, when you are taking a short break from your work.

Progressive Relaxation

Through teaching you to systematically tense and then relax muscle groups of your body, this exercise will help you learn to relax various parts of your body and help you understand how relaxation feels. Again, read the exercise before you begin, then put the book aside and do it from recall. Or, you might want to make a tape recording of this exercise—reading it into the microphone with soft music in the background. Be sure you leave yourself plenty of time on the tape to tense and relax your muscles. You could also have a good friend or counselor read it to you.

Always do this exercise in a quiet space where you will not be disturbed. You can do it either lying on your back or sitting in a chair, as long as you are comfortable.

Close your eyes. Clench your right fist as tightly as you can. Be aware of the tension as you do so. Keep it clenched for a moment. Now relax. Feel the looseness in your right hand and compare it to the tension you felt previously. Tense your right fist again, then relax it. Again, notice the difference.

Now clench your left fist as tightly as you can. Be aware of the tension as you do so. Keep it clenched for a moment. Now relax. Feel the looseness in your left hand and compare it to the tension you felt previously. Tense your left fist again, relax it, and again notice the difference.

Bend your elbows and tense your biceps as hard as you can. Notice the feeling of tightness. Relax and straighten out your arms. Let the relaxation flow through your

arms and compare it to the tightness you felt previously. Tense and relax your biceps again.

Wrinkle your forehead as tightly as you can. Now relax it and let it smooth out. Feel your forehead and scalp becoming relaxed. Now frown and notice the tension spreading through your forehead again. Relax and allow your forehead to become smooth.

Close your eyes now and squint them very tightly. Feel the tension. Now relax your eyes. Tense and relax your eyes again. Now let them remain gently closed.

Now clench your jaw. Bite hard and feel the tension through your jaw. Now relax your jaw. Your lips will be slightly parted. Notice the difference. Clench and relax again.

Press your tongue against the roof of your mouth. Now relax. Do this again.

Press and purse your lips together. Now relax them. Repeat this.

Feel the relaxation throughout your forehead, scalp, eyes, jaw, tongue, and lips.

Hold your head back as far as it can comfortably go and observe the tightness in your neck. Roll it to the right and notice how the tension moves and changes. Roll your head to the left and notice how the tension moves and changes. Now straighten your head and bring it forward, pressing your chin against your chest. Notice the tension in your throat and the back of your neck. Now relax and allow your shoulders to return to a comfortable position. Allow yourself to feel more and more relaxed. Now shrug your shoulders and hunch your head down between your shoulders. Relax your shoulders. Allow them to drop back and feel the relaxation moving through your neck, throat, and shoulders; feel the lovely, very deep relaxation.

Give your whole body a chance to relax. Feel how comfortable and heavy it is.

Now breathe in and fill your lungs completely. Hold your breath and notice the tension. Now let your breath out and let your chest become loose. Continue relaxing, breathing gently in and out. Repeat this breathing several times and notice the tension draining out of your body.

Tighten your stomach and hold the tightness. Feel the tension. Now relax your stomach. Now place your hand on your stomach. Breathe deeply in your stomach, pushing your hand up. Hold for a moment and then relax. Now arch your back without straining, keeping the rest of your body as relaxed as possible. Notice the tension in your lower back. Now relax deeper and deeper.

Tighten your buttocks and thighs. Flex your thighs by pressing your heels down as hard as you can. Now relax and notice the difference. Do this again. Now curl your toes down, making your calves tense. Notice the tension. Now relax. Bend your toes toward your face, creating tension in your shins. Relax and notice the difference.

Feel the heaviness throughout your lower body as the relaxation gets deeper and deeper. Relax your feet, ankles, calves, shins, knees, thighs, and buttocks. Now let the relaxation spread to your stomach, lower back, and chest. Let go more and more. Experience deeper and deeper relaxation in your shoulders, arms, and hands, deeper and deeper. Notice the feeling of looseness and relaxation in your neck, jaws, and all your facial muscles. Now just relax and be aware of how your whole body feels before you return to your work in this book.

How did you feel before you did this exercise?

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How did you feel after you did this exercise?

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Here are some other ways that will help you release feelings and relax your body or specific parts of your body.

- If you can afford it, have a regular massage with a certified massage therapist.
- Take a warm bath as often as possible. If you wish, scent the water with lavender oil or some other scent that you find calming and relaxing.
- Gently rub parts of your body. If it feels comfortable, ask a friend or your partner to do this for you.
- Learn yoga. There are many good books that will teach you how to stretch and relax your body.
- Drink a cup of soothing herbal tea such as chamomile.
- Eat dairy foods, turkey, and leafy green and yellow vegetables—they contain calcium and will help you relax.
- Avoid foods that contain caffeine—coffee, black tea, soda, and chocolate—as they will make you feel more anxious.
- Avoid using alcohol or drugs to help you feel more relaxed and comfortable. While it may help briefly, it will make things much worse in the long run.

Dealing with Unusual Feelings, Sensations, and Responses

You also may have noticed that you have unusual feelings, sensations, and responses to certain events. For instance, if you see a car of a certain make and color, you may feel a sense of fear and dread. If a person you love speaks to you in a certain way, you may recoil in horror though what they said was perfectly acceptable. This is another example of the body remembering what the mind has forgotten. Your

body is responding to situations, circumstances, and events that happened in the past. It is responding in ways that are no longer necessary and that interfere with your life, sometimes making you and others feel bad.

Describe some times when you have noticed unusual feelings, sensations, and responses to certain everyday events.

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As you become aware of these situations, you can respond in ways that will help you feel better quickly and help you respond appropriately to the actions of others. Try getting in the habit of responding to these feelings in one or more of the following ways.

- Stop what you are doing. Breathe in slowly and deeply, paying close attention to your breath. Let the breath out very slowly, again paying close attention. Do this three or four more times. Notice the feeling of relaxation in your body after you do this.
- Do a reality check. Ask yourself the following questions:
    1. What is really going on here? Is this response helping or is it making the situation worse?
    2. Are my feelings or is my response really appropriate to the situation, or is it based on something I learned in the past that is no longer applicable?
- Count to ten, or even a hundred.
- Take time out and do something you really enjoy—read a chapter in a good book, play with your dog, listen to a musical piece you like, or draw a picture.
- Talk to a friend about what happened.

List other ways you have discovered to respond to unusual feelings, sensations, and certain events.

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Ending Ritual

Describe something you are looking forward to that is happening soon.

Describe something you are looking forward to that will happen in the more distant future.

Optional Activity

Get a book on relaxation and stress-reduction techniques. Practice the exercises that are described, and make tape recordings of these that you find to be particularly helpful. For three titles that we especially like, see the Relaxation and Stress Reduction section of the Resources list at the back of this book.[1]

Things to Remember Every Day

- I can teach my body new ways of responding to feelings, sensations, and events in my life.
- I am in charge of my responses.

[1] This is referring to the Copeland & Harris book, not the *NPW Consumer Curriculum*.

WHAT IS POST-TRAUMATIC STRESS DISORDER (PTSD)?*

Introduction

There is a growing awareness among healthcare providers that traumatic experiences are widespread and that it is common for people who have been traumatized to develop medical and psychological symptoms associated with the experience.

Recent studies have shown that childhood abuse (particularly sexual abuse) is a strong predictor of the lifetime likelihood of developing PTSD. Although many people still equate PTSD with combat trauma, the experience most likely to produce PTSD is rape. PTSD is associated with an extremely high rate of medical and mental health service use, and possibly the highest per-capita cost of any psychological condition.

But there is help and there is hope.

PTSD is a long-term problem for many people. Studies show that 33-47 percent of people being treated for PTSD were still experiencing symptoms more than a year after the traumatic event. Without treatment many people continue to have PTSD symptoms up to ten years after the traumatic event.

What are the symptoms of PTSD?

PTSD symptoms are divided into three categories. People who have been exposed to traumatic experiences may notice any number of symptoms in almost any combination. However, the diagnosis of PTSD means that someone has met very specific criteria. The symptoms for PTSD are listed below.

Intrusive Re-experiencing. People with PTSD frequently feel as if the trauma is happening again. This is sometimes called a flashback, reliving experience or abreaction. The person may have intrusive pictures in his/her head about the trauma, have recurrent nightmares or may even experience hallucinations about the trauma. Intrusive symptoms sometimes cause people to lose touch with the "here and now" and react in ways that they did when the trauma originally occurred. For example, many years later a victim of child abuse may hide trembling in a closet when feeling threatened, even if the perceived threat is not abuse-related.

Avoidance. People with PTSD work hard to avoid anything that might remind them of the traumatic experience. They may try to avoid people, places or things that are reminders, as well as numbing out emotions to avoid painful, overwhelming feelings. Numbing of thoughts and feelings in response to trauma is known as

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"dissociation" and is a hallmark of PTSD. Frequently, people with PTSD use drugs or alcohol to avoid trauma-related feelings and memories.

Arousal. Symptoms of psychological and physiological arousal are very distinctive in people with PTSD. They may be very jumpy, easily startled, irritable and may have sleep disturbances like insomnia or nightmares. They may seem constantly on guard and may find it difficult to concentrate. Sometimes persons with PTSD will have panic attacks accompanied by shortness of breath and chest pain.

Who gets PTSD?

PTSD can affect anyone at any age who has been exposed to a traumatic event where he/she experienced terror, threat (or perceived threat) to life, limb or sanity and his/her ability to cope was overwhelmed. Conservative estimates show that nine-ten percent of the general population has PTSD. Among people who were victims of specific traumatic experiences (rape, child abuse, violent assaults, etc.), the rate of PTSD is 60-80 percent.

Diagnosis

Unfortunately, it is common for those with PTSD to avoid treatment. Also, it is common for those who do seek treatment to be misdiagnosed. Because PTSD often occurs at the same time as other physiological and mental health disorders, PTSD symptoms may be masked or difficult to identify. Examples of common co-occurring conditions are depression, substance use/dependence and bipolar disorder. Trauma survivors may also experience headaches, chest pain, digestive or gynecological problems as well. However, there is a growing number of clinicians who are skilled at recognizing PTSD and still others who are specializing in treatment of traumatic stress disorders. If you think you might have PTSD you should seek professional help for a thorough physical and mental health assessment.

Can PTSD be treated?

Yes. A person who has survived a traumatic event will probably never feel as if the event didn't happen, but the disruptive, distressing effects of PTSD are completely treatable. Depending on the source of the trauma (manmade vs. natural), the nature of the trauma (accidental vs. purposeful), and the age of the victim at the time of the trauma, treatment strategies may vary. Treatment involves both managing symptoms and working through the traumatic event. Most experts agree that psychotherapy is an important part of recovery. Medications can help reduce some symptoms allowing psychotherapy to be more effective.

Where can I get more information?

Sidran Institute for Traumatic Stress Education and Advocacy is the only national nonprofit, charitable organization specifically devoted to providing mental health information and referral services, technical assistance, resources, publications, and education to survivors of psychological trauma, their supportive family members

and mental health care service providers. Our mission is to support trauma survivors through advocacy, education and research.

The Sidran Press publishes books and educational materials on traumatic stress and dissociative conditions. New in 2002, *The Essence of Being Real: Relational Peer Support for Men and Women who Have Experienced Trauma* gives survivors a framework for developing peer support groups that facilitate hope and the power of relationships. *Growing Beyond Survival: A Self-help Toolkit for Managing Traumatic Stress* is a symptom management workbook for trauma survivors. Recent titles include the *Risking Connection* trauma training curriculum for mental health providers and workbooks *Managing Traumatic Stress through Art* and *The Way of the Journal*.

The Sidran Bookshelf on Trauma and Dissociation is an annotated mail order catalog of the best in clinical, educational, and survivor-supportive literature on post-traumatic stress and dissociative conditions and related subjects. The catalog is available online.

Sidran Education and Training Services provide professional and survivor training on many trauma-related topics, including Trauma Symptom Management. We will be glad to customize presentations for the specific needs of your agency. Sidran has also developed educational workshops on the psychological effects of severe trauma for a variety of audiences.

WHAT ARE TRAUMATIC MEMORIES?*

Introduction

Recent debates between differing schools of scientific thought, fueled by the media and by lay organizations with varied political agendas, have left the public confused and misinformed regarding the nature of traumatic memories. This confusion is causing great distress to many people who are survivors of child abuse and those who care about them.

The purpose of this brochure is to reach beyond the hype of popular media and the rhetoric of single-purpose organizations to clarify the issues and to discuss the body of knowledge agreed upon by most mental health professionals about traumatic memories and their retrieval.

There is strong documentation to prove the high incidence of child abuse in the general population. Sexual abuse of children and adolescents is known to cause severe psychological and emotional consequences. Adults who were sexually abused in childhood are at higher risk for developing a variety of psychiatric disorders, including dissociative disorders (such as dissociative identity disorder/multiple personality disorder), anxiety disorders (panic attacks, etc.), personality disorders (borderline personality disorder, etc.), mood disorders (such as depression), PTSD, and addictions.

In order to understand the essential issues about traumatic memory, one must first understand the human mind's response to a traumatic event.

What is trauma, and how do people cope with it?

Psychological "trauma" is defined by the American Psychiatric Association as "an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others." Examples include military combat, violent personal attack, natural or manmade disasters, and torture. For children, sexually traumatic events may include age inappropriate sexual experiences without violence or injury (DSM IV, p. 424).

Like adults who experience trauma, children and adolescents who have been abused cope by using a variety of psychological mechanisms. One of the most effective ways people cope with overwhelming trauma is called "dissociation." Dissociation is a complex mental process during which there is a change in a person's consciousness which disturbs the normally connected functions of

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identity, memory, thoughts, feelings and experiences (daydreaming during a boring lecture is a good example).

How does trauma affect memory?

People may use their natural ability to dissociate to avoid conscious awareness of a traumatic experience while the trauma is occurring, and for an indefinite time following it. For some people, conscious thoughts and feelings, or "memories," about the overwhelming traumatic circumstance may emerge at a later date. This delayed retrieval of traumatic memories has been written about for nearly 100 years in clinical literature on military veterans who have survived combat.

In fact, in Post Traumatic Stress Disorder (PTSD), a psychiatric diagnosis common among people who have survived horrific events, the defining diagnostic features are memory distortions. People with PTSD inevitably experience extremes of recall regarding traumatic circumstances: intrusive memories of the event (hypernesia) or avoidance of thoughts and feelings about the event (amnesia).

> Some people say they are "haunted" by memories of traumatic experiences which intrude on and disrupt their daily lives. They often can't get the "pictures" of the trauma out of their heads. They may have recurring nightmares, "flashbacks," or they may even relive the trauma as if it was happening in present time.

It is also common for traumatized people to make deliberate efforts to avoid thoughts or feelings about the traumatic event and to avoid activities or situations which may remind them of the event. In some severe cases, avoidance of reminders of the trauma may cause a person to have "dissociative amnesia," or memory blanks for important aspects of the trauma.

Why do some people undergoing extreme stress have continuous memory and others have amnesia for all or part of their experience?

There are several factors which influence whether a traumatic experience is remembered or dissociated. The nature and frequency of the traumatic events and the age of the victim seem to be the most important. Single-event traumas (assault, rape, witnessing a murder, etc.) are more likely to be remembered, but repetitive traumas (repeated domestic violence or incest, political torture, prolonged front-line combat, etc.) often result in memory disturbance. The extremely stressful experiences caused by natural or accidental disasters (earthquakes, plane crashes, violent weather, etc.) are more likely to be remembered than traumatic events deliberately caused by humans (i.e. incest, torture, war crimes). People who are adults when they experience traumatic events are less likely to dissociate conscious memories of the events than children who experience trauma. Research shows that the younger the child is at a time of the trauma, the less likely the event will be remembered.

Case studies show that traumatic events in which there is pressure towards secrecy are more likely to induce forgetting as a dissociative defense. For example, a woman who is brutally attacked by a stranger but who receives sympathy, family support, and many opportunities to tell her story, may suffer from PTSD, but is unlikely to develop amnesia for the event. However, a young girl who endures repeated incest with her father and has been sworn to secrecy will more likely have memory impairment for the abuse.

Factors Influencing Continuous Memory	**Factors Influencing Dissociation/Amnesia**
Single traumatic event	*Multi-event (repetitive)*
Natural or accidental cause	*Deliberate human cause*
Adult victim	*Child victim*
Validation and support	*Denial and secrecy*

Clinical evidence indicates that the population most likely to develop amnesia for traumatic experiences consists of child victims coerced into silence about repetitive, deliberately caused trauma such as incest or extra-familial physical, emotional, or sexual abuse. Another factor that contributes to memory disturbances is the double-bind felt by children trying to make sense of living in abusive relationships on which they depend for nurturance. Doctors or therapists can have an indication of dissociative amnesia if there are gaps or blank periods in a person's autobiographical memories.

What is known about how memories work?

Human memory is a complex operation. Although there is still much to learn about how memories work, scientists generally understand and accept that there are four stages of memory: intake, storage (encoding), rehearsal, and retrieval. Each of these processes can be influenced by many factors such as developmental stage, setting, expectation, post-event questioning, etc. Even the conditions at the time of the telling of a memory can change the form of the memory, influencing its content and belief in the truth of the memory in the future.

Most scientists also agree that there are two identified forms of memory: explicit and implicit. Explicit memory, also called declarative or narrative memory, is the ability to consciously recall facts or events. This is the form of memory used, for example, when a person recounts the events of his or her day at work or school. Implicit memory, also called procedural or sensorimotor memory, refers to behavioral knowledge of an experience without conscious recall. A person who demonstrates proficiency at reading but who cannot remember how he or she learned the skill is an example of implicit memories in the absence of explicit memories.

Why are traumatic memories controversial?

There are differing schools of thought, grounded in solid research and clinical experience, about the reliability of memory. The details of this scientific debate are often obscure, and the subtleties can be confusing to the public.

Some researchers have proven in the laboratory that ordinary or slightly stressful memories are easily distorted. These scientists are concerned that therapists may be unintentionally distorting the memories of people who report histories of traumatic abuse. This is of particular concern to scientists studying the effects of hypnosis on eyewitness testimony because there is laboratory evidence that setting and expectation can "contaminate" a person's memories.

However, this laboratory research on ordinary memory may be irrelevant in regard to memories of traumatic experiences. Scientists argue that traumatic memories are different from ordinary clinical memories in the way they are encoded on the brain. There is evidence that trauma is stored in the part of the brain called the limbic system, which processes emotions and sensations, but not language or speech. For this reason, people who have been traumatized may live with implicit memories of the terror, anger, and sadness generated by the trauma, but with few or no explicit memories to explain the feelings. Trauma clinicians believe that implicit memories are not easily distorted. It would, of course be unethical to create in a laboratory setting the traumatic experiences necessary to study traumatic memories and their ease of contamination or distortion. For this reason, our knowledge of traumatic memories must come from clinical experience. Clinical data since 1919 has shown a direct correlation between trauma and amnesia or other memory disturbance (van der Kolk, 1994).

What about memory retrieval long after the trauma?

Sometimes a current event or experience may trigger long-forgotten memories of earlier trauma. Often when this happens, the person may be "flooded" with implicit sensorimotor memory: he or she may have just the picture, the feeling, the physiological panic aroused by the memory of the traumatic event without the facts that would explain the meaning of the sensations. Initially, the person may not even be aware of what has triggered the memory, or how the pictures and feelings relate to his or her life.

There is often intense psychological distress when a person is exposed to events which in some way resemble or symbolize the past trauma. These "triggers" may be any sound, smell, or other stimulus such as hot, humid weather which may remind a veteran of his service in southeast Asia, or the smell of a particular cologne which was worn by an abuser.

Can I believe my memories?

At this time, there is no completely accurate way of determining the validity of abuse reports without external corroboration, and that kind of corroboration is often

impossible. Many things -- questioning (especially of young children), suggestion by a trusted person, even the recounting of a traumatic experience in therapy -- may influence the accuracy of abuse memories. Even people who have documented corroboration about their abuse may have inconsistent elements in their stories.

Nevertheless, trauma specialists such as Harvard's Dr. Bessel van der Kolk believe that "the body cannot lie." If a person spontaneously sees a flashback and feels terrified, the feeling can be trusted, especially before an implicit memory has been discussed and possibly contaminated. If the person has the symptoms of PTSD, or a dissociative disorder that is known to be associated with a traumatic history, then it is likely that there are real traumatic experiences in the person's background. Unless one is preparing for a criminal investigation, the exact authenticity of a specific memory may not be important.

It is the job of the individual to figure out his or her own life history. Many people with post-traumatic stress or dissociative disorders have found it helpful to gather information from siblings or other family members to help them understand their memories.

What can I expect from therapy?

A therapist can help by showing a person how to put these memories in the context of other psychological symptoms, and guide them in the process of getting on with their lives. A good therapy situation is a collaborative effort in which the client can feel comfortable taking the lead; a competent therapist may inquire about but generally does not suggest an abuse history. Uncovering memories is only one step in the process of healing from trauma. Other therapy goals may include learning to live with feelings, handling anger, dealing with cognitive distortions, ending a cycle of repeated victimization, etc.

A client should feel comfortable about the relationship with a therapist, and feel free to make decisions about the direction and pacing of treatment. A good therapist is willing to be flexible. Ultimately, the decision about whether or not specific memories are valid is the responsibility of the client.

If you have been diagnosed with a dissociative disorder or PTSD, it would be most helpful to see a therapist with a specialty in these areas. Names of therapists who have experience treating trauma survivors are available through the Sidran Foundation. To practice their specialty, therapists should have a license from the state in which they work. If you have doubts about the progress of your therapy, seek a second opinion from a well-credentialed expert.

What about hypnosis?

The use of hypnosis in trauma therapy is quite common and careful use of hypnotherapy can be helpful but it also can be problematic if used imprudently. Many people think that memories recovered while under hypnosis are more valid than memories retrieved under other circumstances. However, research has shown that hypnotically-retrieved memories may be more prone to distortion.

One of the best uses of hypnosis in trauma therapy is for stabilization: to help a person focus on tasks of daily functioning, and to manage the pain of traumatic memories. People with dissociative disorders often find hypnotherapy helpful in fostering cooperation between dissociated parts or alters.

The uncovering of forgotten memories needs to occur in the larger context of treatment for psychiatric distress or disability. For some people, hypnosis may not be necessary at all. It is, however, generally not appropriate to use hypnotherapy as a "digging tool" to find out if a person has been traumatized.

Any client whose therapist suggests the use of hypnosis should be an informed consumer and ask about the purposes of this type of therapy. A good therapist will get informed consent (preferably in writing) from a client before beginning any course of treatment, including hypnotherapy. This means that before hypnosis is used, the client will be informed of the purposes, benefits, and risks of, and alternatives to this type of treatment, and will (without coercion) agree to its use.

What do I do if I can't remember?

Not all abuse or trauma survivors can clearly remember their traumatic experience/s. Some individuals have only a vague recollection of "something" happening; others can't recall anything traumatic occurring in their lives at all. Traumatic stress symptoms can be extremely distressing for people who have no concrete trauma memories to explain what they are feeling. Common thoughts may include:

- "I can't feel this way for no reason."
- "No one will believe how I feel if I can't explain what happened to me."
- "I am afraid I will never remember."

Even before you begin to tackle the issue of traumatic memories, the first critical aspect of your therapeutic work will be to stabilize your current functioning. Memory loss related to traumatic experiences may serve as a protective function, which should be respected. "Digging up" the past will not alleviate your current difficulties. There is no such thing as a "quick fix" or "skipping steps" when it comes to healing from trauma. Without first establishing the necessary framework for a healthy lifestyle and level of functioning in the present, the challenges of coping with and integrating memories of past trauma may further add to your current difficulties and symptoms.

Therefore, it is highly valuable to first work on your present life issues, the problems that you can more readily identify and address. This will provide you with a solid foundation for further therapeutic work dealing with possible traumatic memories.

If you are struggling with memory disturbances related to trauma or abuse, it is important for you to know you are not alone in this experience and you are not "going crazy." Here are some helpful things to keep in mind:

- Recognize that there *is* a reason for your current difficulties; your "symptoms" are meaningful. They did not come from "nowhere."
- Trust in your own process and timing.
- Find a treatment provider with whom you can establish a safe and trusting therapeutic relationship.
- Acknowledge the idea that symptoms of traumatic stress (such as nightmares or "flashbacks") should not be used to determine the exact nature of the trauma that may be causing your memory disturbances. Beware of drawing conclusions based on the types of symptoms you are presenting. This precaution in no way diminishes the value of your past and present story but is intended to strengthen the authenticity of your symptoms and experiences.

Just as it takes time to build strong foundations of trust and deep roots of connection in relationships with others, so too must you establish these elements internally to strengthen an inner connection within yourself. This will greatly support the work you do both therapeutically and individually.

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SCHIZOPHRENIA, TRAUMA AND RECOVERY*

A lot of people including many professionals believe that a person who has the diagnosis of Schizophrenia primarily just needs treatment with psychotropic medication to stabilize. But there is a growing body of knowledge to the affect that many symptoms of schizophrenia; hallucinations, paranoia, self-destructive delusional systems, and bizarre behavior may have roots in traumatic experience. We are learning that trauma can cause chemical changes in the brain and a wide range of mental health symptoms. And we need to recognize the value of trauma counseling and educational services for people who are diagnosed Schizophrenic.

Let me share the story of B. He carried the diagnosis of Schizophrenia when I met him. His symptoms included hearing voices, visual hallucinations, frequent catatonic periods, and violent behavior such as brandishing a knife at caregivers while in a trance state, a history of suicide attempts, and long-term psychiatric hospitalization. Soon after engaging in supportive counseling B began to share a complex delusional system, which incorporated the voice and presence of a dominating person. Additionally, the story of many years of childhood sexual and physical abuse by multiple perpetrators began to unfold as well as multiple sexual abuse experiences suffered while an in-patient in psychiatric hospitals. As the therapy progressed the delusional dominator began to be less intrusive and was eventually integrated as part of my client's personality. Through eight years of therapy my client's diagnosis changed from Schizophrenia to Post Traumatic Stress Disorder (PTSD) and finally to Adjustment Disorder - (adjusting to being healthy and independent). This client, while meeting diagnostic criteria of Schizophrenia, would have been able to receive more appropriate therapy had someone explored his trauma issues years earlier and used a PTSD diagnosis instead.

Even those who have correctly been diagnosed with Schizophrenia, because of their vulnerability socially, often have layers of trauma and abuse to cope with. That is why it is time to move to a recovery model of mental health treatment. With the support and appropriate counseling many seriously mentally ill people are recovering to greater extents than was ever thought possible.

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*Ellen Magee, MSW (2002). Written for the *New Partnerships for Women Consumer Curriculum.* The author grants permission to reprint this article. Citation of the source is appreciated.

SIV: ROOTS AND REASONS*

This editorial of THE CUTTING EDGE explores the reasons Self-Inflicted Violence (SIV) exists in the lives of many women, and identifies some of the most common "triggers" experienced for self-injury. Many of your shared thoughts and experiences have clarified both the complexity as well as the simplicity of SIV. SIV, in the simplest perspective, is a method of managing extreme discomfort. The discomfort takes many forms and, therefore; the specific triggers for SIV are varied and sometimes convoluted. It may take some time for one person's reasons for SIV to be made clear. The primary thought that SIV is a tool for managing intense difficulties, however, remains as the basis for its existence.

One of the most commonly given purposes for SIV is the relief it provides from intense and very uncomfortable emotions. The most public figure to discuss SIV, the late Princess Diana of Wales, said that she cut herself "because I was in so much pain." Feelings of terror, rage, despair and grief may be experienced as psychically insurvivable and are, therefore, experienced as threatening to survival. Indeed, people who suicide often state that unbearable emotions precipitated their deaths. SIV provides a short-circuit to these emotional states—the self-injury brings about a shift in focus and the experience of diminished emotional intensity. A preferable feeling of numbness is oftentimes the result of SIV when it is used to cope with emotional pain. Indeed, it is not unusual to learn that many women living with SIV feel strongly that using SIV as means of coping with such profound internal turmoil has kept them from committing suicide. This is a very different perspective from the one held by some mental health professionals that SIV is a form of "mini-suicide" or a "suicidal gesture."

Managing anger, fury, or rage can be difficult for many women living with SIV. SIV disperses those feelings by directing them at oneself rather than an external person. Oftentimes people fear their own natural and very human potential for violence when they have feelings of great anger. For those who fear their own potential, SIV may be an ethically preferred means of dispersing the emotion. This is by no means an insinuation that women living with SIV are prone to violence. Rather, very few women living with SIV are violent. However, many of us are fearful of the emotions that precede violence in others and utilize the SIV to manage emotions that even hint at violence.

Self-hatred is also, unfortunately, not an uncommon experience for women living with SIV, and self-injury may serve as a means of expressing it. An unrealistic self-image and self-expectations may predispose someone to perfectionist standards that they cannot possibly meet. When expectations are not met, self-hatred can be triggered. That self-hatred can then serve as a trigger for SIV. For example, anger at oneself for a mistake can feel resolved by a punch to the head. The tension of the mistake triggers the self-hatred and shame, the SIV resolves the difficult emotions, and the person can then go on. This self-hatred is also often triggered by feelings of

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* Ruta Mazelis, Fall, 1998. The Cutting Edge, 9, 3(35): 1-8. For more information email rutamaz@eohio.net.

profound shame and guilt, whether realistic or not. Shame is perhaps the most painful human emotion and can easily trigger SIV when it is experienced.

Increasing stress, the feeling of internalized pressure, is also diminishable with SIV. Because of trauma and its resultant need for safety, a survivor scrutinizes her environment diligently and frequently. On a daily basis this results in a high stress level, and is common among women living with SIV. As such, one is susceptible to triggers from the past accompanied by a consistent feeling of tension in the present. Alertness in the abuse survivor, once necessary for safety in the past, becomes overwhelming and stressful when carried into the present. SIV serves to diminish the stressful buildup.

Whereas SIV is used as a coping mechanism to manage excruciating emotional states, it can also serve to alter feelings of profound numbness or deadness. Clinically known as dissociation, many women living with SIV experience a sense of strong detachment from themselves. They may feel disconnected from their physical bodies, and turn to SIV to "reattach" to them. A woman who cuts herself to the point of drawing blood uses the reality of the blood to recognize her physical self, to know that the body she has cut is truly her own. This process can seem oppositional to the one occurring when SIV is used to ameliorate feelings. SIV seems to be an effective tool for managing dissociation in both directions—to facilitate it when emotions are overwhelming, as well as to diminish it when one feels too disconnected from oneself and the world.

SIV can also be one of the ways a woman attempts to communicate her internal pain to the outside world when she is unable to express herself verbally. As Janice McLane has written, SIV can serve as "a voice on the skin." This is very different from the perspective traditionally held by the mental health community that SIV is a simple "attention-seeking" behavior. In reality, most women who live with self-injury are extremely secretive about it, and fearful and ashamed of its existence. This is far different from the perception of us as wild bleeding women who are desperate for attention whatever form it may take. Actually, the "attention" often given to those living with SIV is usually harmful and often brutal. Exposing one's life as including SIV puts woman at risk of being forcibly hospitalized, restrained, secluded, and/or medicated. This is not the form of attention people desire. Rather it is punishment for a behavior seen to be both superficial and horrific at the same time. Communicating via SIV may be the only avenue a woman has. Self-injury can let us, and those we choose to tell about it, know that we are suffering and are having a very difficult time expressing or externalizing that suffering.

Trauma itself can be communicated via SIV, particularly the trauma of abuse. Those consciously unaware of previous abuse in their lives may find it surfacing later on, when they are emotionally safer, in the form of re-enactments. For example, a woman who was beaten by her father for expressing anger towards him may find herself punching herself in the face when she feels anger towards a man in an authoritarian position. She may not be aware of the connection between the past and the SIV in the present. Many women living in with SIV fear for their sanity until they become aware of the connection between SIV in the present and trauma in the past.

Survivors of rape and other forms of sexual abuse, including sexual harassment, may self-injure the parts of their bodies that they hold "accountable" for the abuse, or that feel "dirty" as a result of it. It is common for women to turn on themselves, as, especially when sexual abuse occurs at a young age, their perpetrators tell them the abuse is their fault. If a girl is told that she was raped because she "looked sexy," then it is understandable that she may later hold those parts of her body accountable for the abuse. Some women then either punish their bodies, especially their breasts and vagina, or re-enact the abuse in an attempt to better manage the complex emotions resulting from it.

Abuse survivors commonly experience flashbacks of their abuse experiences. These are often unwanted global or fragmented memories of the traumatic events, and are very uncomfortable to experience. SIV may be part of the flashback itself, or may be utilized to stop the flashback process if it gets overwhelming. SIV is also a means of depicting previous abuse without having to resort to using words to "tell." Many survivors of abuse have been warned not to "say a word" about it, and have been threatened with harm to themselves or others if they dared to tell. This warning can invoke fear and silence even decades later. SIV may be the first form of expression a person has to begin disclosing the secrets of the past.

SIV can occur in the context of relationships, as it is in relationships that painful feelings can be experienced. Trauma itself impacts one's connection with oneself, others, and the world at large. SIV is connected to intimacy, as it is a tool of connection and expression when other means are not possible as a result of traumatic wounds. Sexual intimacy is often problematic for abuse survivors, and SIV serves the function of managing some of the difficulties that arise with sexuality. Human beings crave many forms of intimacy, yet not all of us are able to know or express our needs. SIV has often been correlated with feelings of abandonment, some of which may be triggered by experiences of neglect in the past as well as the present. A woman who has been neglected in childhood, and who uses SIV as a coping tool, may further feel abandoned and neglected when others in her life demean her for needing the SIV.

Women living with SIV might have confusion regarding personal boundaries, whether psychological, emotional, or physical ones. Some of us experience ourselves as having rigid, protective walls, while others feel overly vulnerable and without barriers to the world and others in it. Many of us experience both at various times. SIV serves as a boundary check for some of us. If confused about one's own physical boundaries, SIV can make one's body objective and real because, for example, a cut can show you where your body starts and that it is substantive. People who struggle to experience boundaries may often be triggered into SIV when they feel invaded and unable to physically or psychically set limits with others.

For those of us whose bodies host a group of personalities (diagnosed as Multiple Personality Disorder, now revised to Dissociative Identity Disorder), SIV can serve a multitude of purposes. Basically, every reason a woman who is not multiple, and who lives with SIV, has for her SIV may be applicable to the woman who is multiple. Different personalities may have different reasons for the SIV. Not all may be aware of each other, and some can experience great fear and confusion about SIV

they are not cognizant of. SIV can be a powerful tool of communication amongst personalities, and can serve as a warning by some to others. Every personality in the system has a purpose and was created from a need for survival. Some are considered protective of the others and may communicate via SIV to them if they feel that the system as a whole is unsafe. This is not an uncommon occurrence when one personality begins to talk about the past abuses out of which the necessity for multiplicity arose. SIV while appearing as anger or punitiveness, is in actuality a caring warning that there is danger in disclosure.

Ritual abuse survivors commonly turn to SIV for a vast variety of reasons. However, one particular aspect of SIV for survivors of sadistic cults is programmed self-injury, which can occur when the victim attempts to disclose the abuse or leave the group. Also, SIV for ritual abuse survivors may occur on anniversary dates of the events experienced earlier, and may include specific representations of ritual symbols.

Some people, but not most women living with SIV, see the problem as purely biological, a defect in the brain chemistry. Others determine it to be an addiction. Psychiatric researchers theorize that the stimulus of SIV results in the production of certain brain chemicals known as endogenous opiods (specifically the endorphins) which produce a type of "high" resembling morphine. It is this narcotic feeling that the person is supposedly addicted to. Interestingly, not one researcher has yet explained why this "drug effect" only occurs with SIV and not accidental injury. If this were a true addiction we would all be at risk of developing it as a result of accidental injury. These theories overlook the one profoundly consistent factor that correlates to SIV—a history of trauma. It could never be (honestly) stated that SIV is simply an addiction because it targets a very specific population. While endorphin release may or may not be associated with SIV, it is also associated with activities such as eating chocolate, exercising, and meditation. And while brain chemistry changes certainly occur with life experiences, the narrowness of the pharmaceutical and psychiatric industries' interests limits the knowledge of brain chemistry changes to what drugs can be created and prescribed to alter those changes. Drug companies that spend a great deal of money influencing physicians and paying for research usually disregard the biochemical effects of therapy and other methods of healing. The business of psychiatry is focused on stopping the symptom of SIV while ignoring the healing of the person living with it.

It is therefore crucial that we not end a discussion of the reasons that SIV exists without exploring the source of the triggers for the SIV. Perhaps a way to conceptualize this is the diagram on the following page.

The various triggers for SIV, such as deeply uncomfortable emotional states, dissociation (both inducing a dissociative state as well as diminishing it), flashbacks and memories, self-image and identity (the trigger of self-hate), boundaries (physical, psychological, emotional), the ability to manage stress, the experience of multiple personalities, and difficulties with intimacy (social relationships, friendships, sexuality), rest on a base of a history of trauma. Traumatic experiences have many consequences and aftereffects. These aftereffects are affected by the nature and

duration of the trauma, the age and experience of the victim, support available at the time, and many other factors, including the individuality of the person surviving the trauma. One of the most consistent experiences inherent in trauma, in my opinion, is the experience of helplessness. Helplessness itself may be the most consistent factor in triggering SIV. A woman living with SIV is using SIV to manage many of the repercussions of trauma. SIV is a survival tool. Just as other tools can be used to help with a variety of circumstances, so too can SIV be a means of managing a range of problems. SIV is powerful—it brings immediate change to situations that have represented powerlessness for a very long time.

In discussing trauma, I imply a wide range of experiences that can have the repercussions mentioned. By far the most common form of trauma linked with SIV is childhood abuse, however; other forms of trauma have certainly been described in the origins of SIV. For example, women who experienced repetitive, invasive (and necessary) medical procedures in their childhoods have turned to SIV to manage some of the repercussions of those experiences. Women who have been raped and people who have been at war may also find a need for SIV. Self-injury is rampant amongst people who have been institutionalized in prisons and psychiatric hospitals as these facilities are traumatic by nature. People who have survived natural disasters, but have lost their loved ones, and others who experience profound grief and despair, may find a temporary soothing and means of expression in SIV as well.

In discussing the traumatic nature of childhood abuse, it is important to understand the range of experiences this involves. The most recent absolute focus on the link between sexual abuse (primarily incest) and SIV is important, yet it is as important to identify the impact of physical and emotional abuses, and neglect as well. These are more common experiences, and often don't receive much-needed acknowledgement. To separate out SIV from its context is to alienate the voice of SIV itself. SIV is a language born of helplessness and pain. Its existence speaks to a life of struggle and survival, of limitations. SIV arises from traumatic roots. It is imperative that we recognize that trauma, in whatever context it is identified, is the ultimate trigger of self-injury. With that understanding we are well on our way to a compassionate and realistic perspective on the lives of women living with SIV.

WOMEN AND SELF-INJURY*

What is self-injury?

"Self-injury" is any sort of self-harm which involves inflicting injuries or pain on one's own body. It can take many forms.

The most common form of self-injury is probably cutting, usually superficially, but sometimes deeply. Women may also burn themselves, punch themselves or hit their bodies against something. Some people pick their skin or pull out hair.

How common is self-injury?

Self-injury is far more widespread than is generally realized. All sorts of people self-injure. Often they carry on successful careers or look after families and there is little outward sign that there is anything wrong. Self-injury seems to be more common among women, partly because men are more likely to express strong feelings such as anger outwardly.

Many women who self-injure believe they are the only person that hurts themselves in this way. Fear and shame may force women to keep self-injury secret for many years. This means that the true extent of the problem is unknown. Our experience shows that where it is acceptable to talk about, many women reveal that they have self-injured at some time.

Why do women self-injure?

There are always powerful reasons why a woman hurts herself. For most women it as a way of surviving great emotional pain.

Many people cope with difficulties in their lives in ways which are risky and harmful to themselves. Some drink or eat too much, smoke, drive too fast, gamble or make themselves ill through overwork or worry. They might do this to numb or distract themselves from problems or feelings they cannot bear to face. (Like "drowning your sorrows.")

Self-injury, though more shocking, bears many similarities to these "ordinary" forms of self-harm. Like drink or drugs, hurting herself may help a woman block out painful feelings. Like taking risks or gambling, it may provide danger and distraction.

Often women say that self-injury helps them to release unbearable tension, which may arise from anxiety, grief or anger. It puts their pain outside, where it feels easier to cope with. For others it relieves feelings of guilt of shame. Sometimes a woman's self-injury is a "cry for help"; a way of showing (even to herself) that she has suffered and is in pain. Perhaps hurting herself is a way of

* Modified from a brochure by the same name from the Bristol Crisis Service for Women, available at: http://www.selfinjury.freeserve.co.uk/women.html. For more information, please visit their web site at: http://www.users.zetnew.co.uk/bcsw, write: PO Box 654, Bristol BS99 1XH, or telephone 0117 925 1119.

feeling "real" and alive, or having control over something in her life. What lies behind women's distress may be painful experiences in childhood or adulthood. A woman may have suffered neglect or abuse, or may have always been criticized or silenced, rather than supported and allowed to express her needs and feelings. Some women who self-injure lost parents early, or came from chaotic or violent families. For others, adult experiences of emotional or physical cruelty have led to their desperation.

Myths about self-injury

Self-injury is a failed suicide attempt. Self-injury is a way of carrying on with life, not of dying. Injuries are seldom life-threatening. It is important to distinguish self-injury from a suicide attempt, so that its true meanings can be understood.

Self-injury is "just attention seeking." Self-injury is primarily about helping oneself cope with great pain. For some, it is a desperate attempt to show that something is really wrong, and attention should be paid to their distress.

Self-injury is a sign of madness. Self-injury is a sign of distress, not madness; a sign of someone trying to cope with her life as best she can.

A person who self-injures is a danger to others. Someone who self-injures is directing her hurt and anger at herself, not at others. Most would be appalled at the idea of hurting someone else.

What can help?

Self-injury causes great distress, and can seem a difficult problem to overcome. But it is possible for a woman to stop hurting herself, if she can understand and resolve the problems behind what she does.

If you are someone who self-injures. Think about what your self-injury is "saying" about your feelings and your life. This will give you clues about problems you need to work on. You might find it helpful to talk about your self-injury and what lies behind it with friends or a counselor.[2]

If you want to help someone who self-injures. Naturally you may feel upset, shocked or angry when someone you care about hurts herself. Try to keep seeing the person in pain behind the injuries. The most precious thing you can offer are acceptance and support. Let your friend know you understand that self-injury is helping her to cope at the moment. She is not "bad" or "mad" for doing it. You could invite her to talk about her feelings, or to call you if she is having a difficult time. But only offer as much as you can cope with, and don't try to take responsibility for stopping her from hurting herself.

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[2] For women who are interested in finding a counselor, Ruta Mazelis, editor of *The Cutting Edge*, has recommended the following book: Robin E. Connors (2000). *Self-Injury: Psychotherapy with People Who Engage in Self-Inflicted Violence.* Northvale, NJ: Jason Aronson Inc. This was not suggested in the original Bristol Crisis Service for Women brochure, but is rather an NPW adaptation.

IN HARM'S WAY: SUICIDE IN AMERICA*

Suicide is a tragic and potentially preventable public health problem. In 1997, suicide was the 8th leading cause of death in the U.S.[1] Specifically, 10.6 out of every 100,000 persons died by suicide. The total number of suicides was approximately 31,000, or 1.3 percent of all deaths. Approximately 500,000 people received emergency room treatment as a result of attempted suicide in 1996.[2] Taken together, the numbers of suicide deaths and attempts show the need for carefully designed prevention efforts.

Suicidal behavior is complex. Some risk factors vary with age, gender and ethnic group and may even change over time. The risk factors for suicide frequently occur in combination. Research has shown that more than 90 percent of people who kill themselves have depression or another diagnosable mental or substance abuse disorder.[3] In addition, research indicates that alterations in neurotransmitters such as serotonin are associated with the risk for suicide.[4] Diminished levels of this brain chemical have been found in patients with depression, impulsive disorders, a history of violent suicide attempts, and also in postmortem brains of suicide victims.

Adverse life events in combination with other risk factors such as depression may lead to suicide. However, suicide and suicidal behavior are not normal responses to stress. Many people have one or more risk factors and are not suicidal. Other risk factors include: prior suicide attempt; family history of mental disorder or substance abuse; family history of suicide; family violence, including physical or sexual abuse; firearms in the home; incarceration; and exposure to the suicidal behavior of others, including family members, peers, and even in the media.[5]

Gender Differences

More than 4 times as many men than women die by suicide;[1] however, women report attempting suicide about 2 to 3 times as often as men.[6] Suicide by firearm is the most common method for both men and women, accounting for 58 percent of all suicides in 1997. Seventy-two percent of all suicides were committed by white men, and 79 percent of all firearm suicides were committed by white men. The highest suicide rate was for white men over 85 years of age—65 per 100,000 persons.

Children, Adolescents, and Young Adults

Over the last several decades, the suicide rate in young people has increased dramatically.[7] In 1997, suicide was the 3rd leading cause of death in 15 to 24 year olds—11.4 of every 100,000 persons—following unintentional injuries and homicide.[1] Suicide also was the 3rd leading cause in 10 to 14 year olds, with 303 deaths among

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 NIH Publication No. 01-4594. For More Information: National Institute of Mental Health (NIMH), Office of Communications and Public Liaison. Public Inquiries: (301) 443-4513. Media Inquiries: (301) 443-4536. E-mail: nimhinfo@nih.gov. Web site: http://www.nimh.nih.gov.

19,097,000 children in this age group. For adolescents aged 15 to 19, there were 1,802 suicide deaths among 19,146,000 adolescents. The gender ratio in this age group was about 4:1 (males: females). Among young people 20 to 24 years of age, there were 2,384 suicide deaths among 17,488,000 people in this age group. The gender ratio in this age range was about 6:1 (males: females).[8]

Attempted Suicides

There may be as many as 8 attempted suicides to 1 completion;[9] the ratio is higher in women and youth and lower in men and the elderly. Risk factors for attempted suicide in adults include depression, alcohol abuse, cocaine use, and separation or divorce.[10,11] Risk factors for attempted suicide in youth include depression, alcohol or other drug use disorder, physical or sexual abuse, and aggressive or disruptive behaviors.[12-14] The majority of suicide attempts are expressions of extreme distress and not just harmless bids for attention. A suicidal person should not be left alone and needs immediate mental health treatment.

Prevention

All suicide prevention programs need to be scientifically evaluated to demonstrate whether or not they work. Preventive interventions for suicide must also be complex and intensive if they are to have lasting effects. Most school-based, information-only, prevention programs focused solely on suicide have not been evaluated to see if they are effective, and research suggests that such programs may actually increase distress in the young people who are most vulnerable.[15] School and community prevention programs designed to address suicide and suicidal behavior as part of a broader focus on mental health, coping skills in response to stress, substance abuse, aggressive behaviors, etc., are more likely to be successful in the long run.

Recognition and appropriate treatment of mental and substance abuse disorders also hold great suicide prevention value. For example, because most elderly suicide victims—70 percent—have visited their primary care physician in the month prior to their suicides,[16] improving the recognition and treatment of depression in medical settings is a promising way to prevent suicide in older adults. Toward this goal, NIMH-funded researchers are currently investigating the effectiveness of a depression education intervention delivered to primary care physicians and their elderly patients.

If someone is suicidal, he or she must not be left alone. You may need to take emergency steps to get help, such as calling 911. It is also important to limit the person's access to firearms, large amounts of medication, or other lethal means of committing suicide.

For More Information

American Association of Suicidology
Phone: (202) 237-2280
Web site: http://www.suicidology.org

American Foundation for Suicide Prevention
Phone: (212) 363-3500
Web site: http://www.afsp.org

Suicide Prevention Advocacy Network
Phone: (770) 998-8819
Web site: http://www.spanusa.org

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THE INSIDIOUS RELATIONSHIP OF TRAUMA AND ADDICTION*

Everyone wants to numb some kind of pain at some point in her life. Survivors of trauma have a lot of stuff to numb out. Emotional numbing is one of the main responses to trauma, and there is a continuum of intensity with which one numbs herself. There are many ways to achieve this state of numbing. Dissociated identities and amnesia are two extremes. Over-eating or obsessive exercising are two common ones.

Another quite popular and rather successful way to numb is with alcohol and drugs. Just like dissociation, getting wasted is merciful. It blocks tremendous amounts of pain, horrendous memories, and makes life seem livable-at least for that moment.

The problem with alcohol and drugs is that they are *addictive!* What was used to soothe away the effects of hell actually kidnaps the brain. Using is not the problem. Using alcohol and drugs is just one more creative coping mechanism used to manage the negative effects of trauma. It is the *addiction* that becomes the problem.

There is a lot of good brain research that has identified the process of addiction. We know what parts of the brain are effected and the result. We know there is a genetic predisposition, but that is not the only factor. The frequency and intensity of use also has an effect.

The important thing to know is that addiction is a brain process. Thoughts of alcohol and drugs, seeing old using buddies, or driving past a bar trigger a part of the brain that activates the craving process, which is a very real, physical sensation. It is similar to a flashback in that one does not have control over the brain's response and subsequent physiological effects. Both are chemical processes that are adaptations to the presence of certain chemicals in the brain. The big difference is that trauma was not a choice, and alcohol and drug use usually is.

As a therapist I saw my clients getting the shit kicked out of them by drugs and alcohol. Some would come in with cuts and bruises. Sometimes they lost things, got raped, or lost all judgment and did things they regretted. They suffered tremendous loss because of alcohol and drugs. When I would say, "drugs are abusing you," they would stare at me for a few moments. I would say, "It is not you who abuses alcohol and drugs. You use them to feel good. That is not the problem. The problem is that the alcohol and drugs take over and kicks the shit out of you, but you can't feel it until the next day!" This twist on the theme of abuse offers great relief to many. They had been labeled an addict for so long that the identity took on a life of its own; a self-fulfilling prophecy. This new definition gives back dignity.

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* By Carin Mizera (2002). Written for the *New Partnerships for Women Consumer Curriculum.* Please contact the author at carin@chorus.net for permission to reprint.

Trauma Bonds

Another definition I share with many of my clients is that of a trauma bond, especially those in abusive relationships. A trauma bond is something that had been first observed in victims of extreme torture, usually prisoners of war. It is known that this same psychological process takes place between victims of physical and sexual violence and their perpetrator. The victim comes to believe that the abuser can take her life at any moment. When this doesn't happen, she experiences the abuser as merciful. That perception becomes a bond and a drive. One begins to try to figure out what it is that will make the abuser happy and not kill her, or not hurt so much. And each time death is not the outcome, the bond becomes stronger. Even if actual death is not a real threat, the brain doesn't differentiate this. It only experiences intense fear.

Understand that this is not a conscious process. It comes out of our innate drive to survive and to believe that we have control over what happens to us. It is through this process that a victim becomes psychologically trauma-bonded to her abuser! This gratitude begins to feel a lot like love. If the abuse is sexual and the body responds as it is designed to, the confusion is even greater. Again, physiologically the relationship that develops feels like love.

The relationship and bond to alcohol and drugs is even more insidious. Even as it is abusing, it is numbing the pain. Sober we may never be at a party and have sex with strangers. But drunk we do, and we don't even have to feel it. Isn't that drug merciful?

I define this relationship with alcohol and drugs as a trauma bond in its own right. It is more dangerous than a loved one telling us we are being beaten for our own good, because he loves us, because we deserved it, then giving us flowers and telling us how much he loves and needs us. It is worse because it numbs the pain before we feel it. It is worse because we are held responsible with no empathy. It is worse because we initiated the process ourselves, adding another false positive to our sense of worthlessness.

Perpetrator of Our Own Abuse

Let's go back to the point about the alcohol and drugs being the abuser. Though the drug takes over and abuses the person, it is the person herself who used the drug in the first place. The choice to use alcohol and drugs did not include abusing oneself, but that was the outcome. (I won't go into the shame felt about what one might do to others while intoxicated, but that also plays a major role.) How many times have we said to ourselves "how could I have done that? I am such a bad person!"

> What began as a choice to just feel good for awhile has now become a complex, confused jumble of psychological and physiological effects. Which brings us back to the beginning of this vicious circle: We are in pain. It is so intense that we seek relief. The alcohol and drugs do a great job of relieving

pain. We use, we're relieved, the drug abuses us, we become physically addicted and psychologically trauma-bonded, and we go spinning into that cycle of shame, denial, desperation, and emotional pain. And at some point it all starts again because the pain becomes too great.

But wait! There's more!

Inability to Feel Good

Alcohol and drugs and trauma affect the brain. We know this. But we are only recently beginning to understand how exactly the brain is effected. One of the most critical effects of alcohol and drugs is that they trigger the "pleasure center" of the brain *instantly*. That's why it feels so good to get off.

For trauma survivors, enjoyment is often a difficult state to achieve. We are often wallowing in depression, hostage to hyper vigilance, or numbed to all emotion. For most people enjoyment is a normal everyday thing, taken for granted. A beautiful sunrise, a good joke, or a puppy can make a day worth living. This doesn't happen for trauma survivors.

Alcohol and drugs do it instantly for you. So once again, mercy *and* a little fun! Unfortunately, the brain eventually becomes incapable of experiencing pleasure without the drug! This is the addiction part that makes it so dangerous. This is one reason why recovery is so difficult! A therapist may suggest we find new activities to build a new life. Whether it is trauma or AODA therapy, the recovery process is much the same. Problem is, the brain is just not up to finding pleasure in anything.

The good news is that the human brain is a miraculous machine and can heal itself given the right conditions. We *can* reprogram our ability to experience happiness and fun. One of the traditional AA phrases, "fake it 'till you make it," is full of intuitive genius. But we know that is not the whole picture.

Healing with La Loba

Healing takes time; we all know that. It is a long journey for many of us. But it is possible. I know this. I am doing it. I know others who are doing it, who are happy, healthy, productive, content, and satisfied people.

This is a fable about *La Loba, The Wolf Woman.*

La Loba is said to live in the dessert gathering bones. She does so quietly, rarely speaking, but often making animal sounds. She gathers all bones, but she specializes in wolf.

When she has collected all the bones she assembles them into a complete skeleton. She gazes at her creation and chooses the song she will sing for this emerging creature. She begins to sing, and as she does the creature begins to flesh out, to grow fur, to tremble with life. La Loba continues her song. The wolf continues to grow.

From the depths of her soul La Loba sings the final notes, and the wolf springs to life and runs free into the wilderness!

As she runs, whether it be a ray from the sun or moon shining in her eye, a splash of water from the river on her fur, or the song of a bird in her ear, the wolf suddenly becomes a laughing woman full of life and love.

We are each of us *La Loba*. La Loba of our own lives, creating our own *wolf-into-woman*. Each day we collect the bones of our experiences and we assemble them in new and creative ways. Maybe we each have a pack of wolves to be reclaimed, and many, many bones to collect. But each bone we collect is usable. And each note of our song we sing grows more flesh on our bones.

Each action we take for our healing is not wasted. We may have come to believe that it is our negative past that rules us and will never go away. Or that our addiction will never leave us at peace.

But this is not true. We have many tools to use to dismantle the effects of trauma and addictions; exercise and good nutrition, support groups and psychotherapy. We work hard to get rid of the pain. It is the shedding of this weight that allows us to use our strength to carry all the good around.

It is known that once we love, even if only a little, that love never goes away; especially love for our own self. It exists in perpetuity. It exists in our mind and our soul, if only we learn to access it and keep that love energy flowing. And this is true for every success, every act of self-love, and no matter how small or short. For every day you did not drink, *that is one more day you did not drink!* No one can take that away from you. No one.

Only our selves will ever know the full extent of our own pain, all the injustices we've suffered. Only our selves will ever know the truth about all the drugs we did and what we remember while using. And now you and I are *La Loba*. Let's give our selves the compassion that we would give our sister if she told us all those stories. Let's begin to gather our bones.

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MENTAL ILLNESS IS A COPING MECHANISM*

Mental illness is a coping mechanism. We know for sure that victims of horrendous childhood sexual abuse, most often by a family member from whom they can't escape, use such coping mechanisms as dissociation (going away in your mind) when they cannot escape physically from the torture. And further down that continuum is multiple personality and amnesia. These are all ingenious and remarkable ways that children learn to survive situations that are intolerable. And many people—without the label of mental illness—use coping mechanisms to survive the stress of everyday life. We use alcohol, drugs, sex, work, exercise, shopping, smoking, eating, gambling—some to excess and some, just enough to take the edge off—but we do use them. In moderation these coping mechanisms are considered socially acceptable; however, going "manic" or becoming "psychotic" is not.

After three years of listening to people call the 800 line at the National Empowerment Center, I must say I have drawn some very strong conclusions. First and foremost, the one thing that is clear to me is that no one calling the National Empowerment Center comes from the "Beaver Cleaver" family. Be it parents, consumers/survivors, siblings, lovers, spouses, or friends, there is always some trauma involved when the story is told: poverty, death of a parent at an early age, abandonment, divorce, incest, alcoholism, drug addiction, neglect, etc. And then the story continues the same. Some time later on in life, always a stressful time in life—off to college, wrestling with sexuality in the teen years, the birth of a child, the death of a parent, a divorce or broken love relationship—it happens. Mania, psychosis, panic attacks, depression, obsessive-compulsive behavior, and agoraphobia—these all of a sudden appear in those who have never known such things. Why? Well think about it logically. Trauma may not cause mental illness, but we all have our breaking points. And I think those of us who are not lucky enough or able to find a socially acceptable way of handling our stress, a way that does not too drastically interfere with our day-to-day lives, may end up becoming manic or going psychotic. What better way to leave behind a reality that is too cumulatively painful than to create one of our own...as in psychosis? What better way to feel like we can accomplish and do anything when we are feeling insecure and overwhelmed than becoming manic...where we can do anything and everything? And what better coping mechanism can we find than to wash our hands fifty times a day when we are feeling so unsafe? And if the world has been a cruel and unforgiving place, where but in the safety of your own bedroom, as in agoraphobia, could there be a safer place to be?

Some would say that mental illness runs in families—that it is genetic. When I was growing up, alcohol was the way in which my Irish Catholic family coped. I watched it all my life. So when I ran into trouble in my early twenties, alcohol was the way in which I self-medicated and tried hard to make the pain go away. My girlfriend down the street grew up in an Italian Catholic family. Food was the drug of choice in her home. Whenever anything emotional happened—a death, a birth, a

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wedding—food was what was used to stuff the feeling. So when my friend's husband left her with two small babies when she was 18, she started eating and did not stop until she had gained 50 pounds. And the same is true with so-called mental illness. If you grow up with depression, suicide, mania and psychosis as role models for coping mechanisms, the more likely you may use these as ways to cope when the need arises.

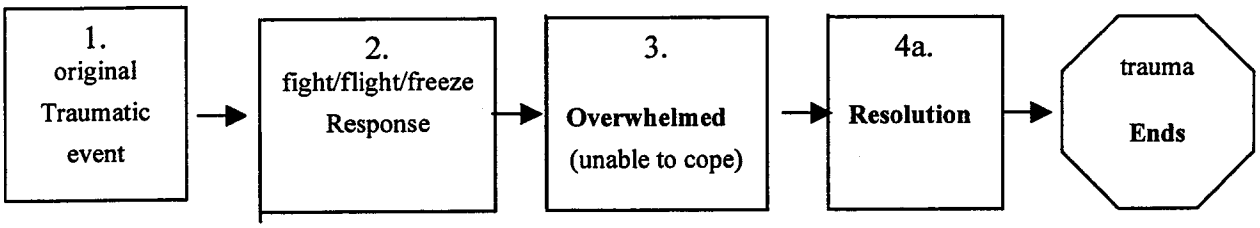
It is not a coincidence that most of the staff at the NEC are trauma survivors—later to be diagnosed with mental illness. But it is also not a coincidence that we have all recovered. We share common ideals and principles that have allowed us to find new coping mechanisms that work in our lives. Drugs, in and of themselves, were not the answer. Electroshock was not the answer. The answer was making it safe for us to come back, and finding a new way to cope with the stress when we did return. You know, if you had a nervous stomach and you went to your doctor, he or she might give you Maalox and Tagamet and tell you to reduce the stress in your life. Well, you could take all the medicine, but if you went home to the car that would not start, the dog who just died, the lover who is cheating on you and the job you hate, you can be pretty sure that your stomach would kick up again—no matter what you take—until you find a new way to cope and deal with the stress in your life.

Mental illness is a coping mechanism, not a disease. And those who know this know that drugs will only fend off the pain for so long and then it comes back again. And it seems to me, the difference between those who recover and those who go on to become chronic, lifelong mental patients are those who are aware of this, those of us who know that a second, third or fourth drug added to our repertoire will not ease the pain. In fact it only increases the pain—when we feel hopeless and helpless. Create a safe space. Find a new way to cope. And I believe you too can recover from your so-called mental illness.

"MAY THE CIRCLE BECOME BROKEN"*

Carin Mizera of New Partnerships for Women has developed an "Effects of Trauma" diagram that wonderfully explains what happens when 1. a trauma event is resolved versus unresolved, 2. the repeat pattern of cyclical symptoms, and 3. how that PTSD cycle can be broken to bring an end to the trauma.

1a. Trauma Resolution Pattern



Where there is resolution to a traumatic event, even though one still has memories of the event and emotions to those memories, the event is not relived and the person is able to go on with their life without being overwhelmed or obsessed with the past trauma. Example -

When I was nine years old, I cut across the parking lot behind a drug store at dusk to get home from a friend's house before dark on a school night. An old man standing behind a dumpster called out to me and asked if I wanted to see something. I squinted at what he was holding and thought it was a vinyl, school-supplies holder in the shape of a pencil I'd been wanting. When I got closer though, I saw it was his penis [trauma] and I stopped, frozen with fear [F/F/F] and remembering a second-grade girl in nearby Racine, WI who'd been raped, then strangled and later found in a thrown-out refrigerator the winter before [overwhelmed]. He asked me if I'd ever seen one before and I nodded yes (to save on the water bill, my mom used to toss several of us pre-school age kids into the tub together on Saturday bath night.)

Then he asked me if I wanted to earn some money and I shook my head no, saying, "I gotta get home before it gets dark or my mom'll be mad."

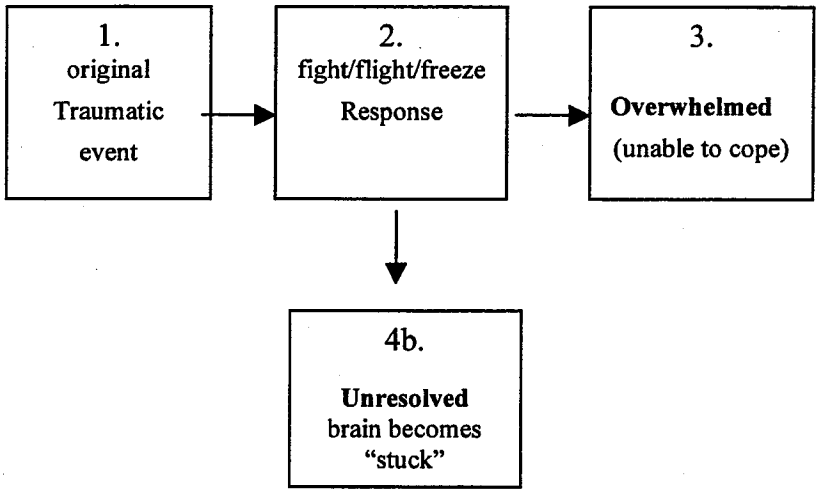
I carefully backed away and as soon as I hit the Main St. sidewalk, I took off running across the bridge and home faster than I've ever run [flight]. Where I chose to not tell of the incident because (taking in account my nine-year old logic whose only knowledge of the law was what I saw on TV) I didn't think I could pick him out of a line-up since he looked liked your average drunk, old white man.

Even though I vividly remember the event, it never drags me into an obsessed, depressed state because I took care of myself. He wanted to do something to me but I got myself out of the situation untouched and intact [resolution]. So when I

* Theresa Swoboda (2002). Written for the *New Partnerships for Women Consumer Curriculum*. Author has granted permission to reprint this article. Citation of the source is appreciated.

remember this, I feel pride for that nine-year old girl who defended herself. Thus, the trauma ended shortly after it began.

1b. Unresolved Trauma Pattern



However, when there is not resolution to a traumatic event, the brain can become stuck repeating the original event over-and-over in conscious or unconscious memory. Example from my past where the trauma still has not ended though the abuse stopped over twenty years ago -

> *On Easter Eve when I was fourteen and a freshman in high school, I was raped by my best friend's father. A periodic molestation that went on for 2½ years before it stopped with him dead on an operating table my senior year. [**trauma**] Whenever he did something, I would freeze and silently stand there, feeling ashamed, scared, embarrassed, and confused. [**freeze response**] His sexual abuse the first time made me so physically ill I stayed in bed all day Easter Sunday and missed school for the first time for an actual sickness since having the measles in second grade. Two days later I got my period and went back to school, wondering how I could face my best friend without saying anything and losing her friendship. [**overwhelmed**] I stayed away for nine months [**flight**] until her birthday in December, and finally went over when she began wondering out loud that maybe we weren't best friends since I never came to visit or spend the night anymore. He didn't do anything that visit, so I figured it was a one time thing. Then the next visit, while kneeling on her bedroom floor gluing together a Santa pom pom ornament, there he was at me again. And I gave up. [**overwhelmed**]*

The trauma went unresolved while it was happening for several reasons: One, because there was no one in my family I could confide in or trust. I was the classic "lost child" growing up in a dysfunctional family. My father was an alcoholic who preferred the two children from his second marriage to us seven kids from the first family, usually only coming to visit when he was drunk and dangerous. My mother had given birth eight times in twelve years and only had so much emotional support to go

around after getting stuck raising all of us on her own before the last one was even born (my dad ditched us for the last time when my mom was seventh months pregnant). As the third oldest and a naturally quiet person, I learned by my teen years to rely only on myself to solve my problems, living by the ACOA creed - "don't talk, don't trust, don't feel".

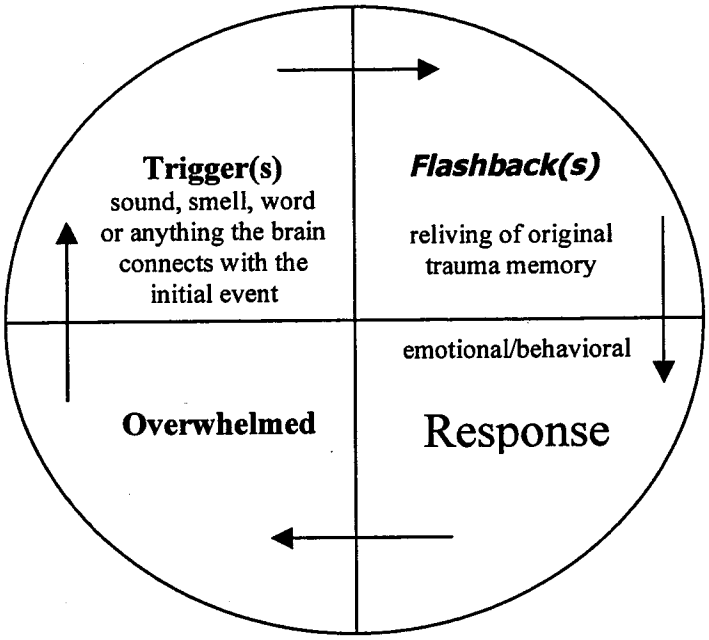
Two, because I was growing up in a very prejudiced, narrow-minded town, I didn't believe that if I told he'd be arrested and imprisoned for the actual crime of raping an underage girl. Another friend of mine was molested by a white high school janitor while working for CETA (an employment program for teens from low-income families). At the trial, it was brought up that he was a deacon of the church while she was called a slut (she didn't even go out on her first date until her senior year!). Needless to say, he was acquitted even though other CETA girls came forward and confessed that he'd made sexual advances at them, too. My family was regarded poorly by the town for being poor. My best friend's father was not white. With all the racism and classism in that small town (which happens in every state in this country, not just the southern ones), I don't believe then-or-now that a fair trial would have occurred. I believe he would have been found guilty based on his ethnic background and that if he'd been white, he probably would have been acquitted because I was from a family on welfare.

Third, and most important, the best way to lose a best friend is to have her father arrested. A very shy person, I only had a couple friends and she was such a good friend, I didn't want to risk anything breaking us up. Plus worry that she and her little brothers would get beaten up and her family would have to move away and become poor themselves if her dad got arrested and lost his job. All of these not because of what he did, but because of his skin color.

So I kept my mouth shut and tolerated his abuse, not knowing what else to do. A pattern began of—he'd do something sexual to me, within a couple days I'd get my period. I'd stay away from my best friend's house for about a month until I ran out of lies about why I couldn't come visit, or my own family was driving me so crazy with physical and verbal abuse, that her home became my only refuge - my only place to escape to although it meant him pawing over me, etc. He'd do something sexual, I'd go back home the next day, within a couple days get my period and begin another month's avoidance of her home until the pressures built up again. And so the sexual abuse kept circling until he died when I was seventeen.

When the trauma goes unresolved and the brain becomes stuck on the event, a vicious PTSD cycle can be set in place where anything related to the trauma (sound, smell, word, or something else) can trigger the event, bringing about a flashback (a conscious or unconscious reliving of the event). When the flashback is experienced, there is an emotional or behavioral response based again on fight/flight/freeze, and again a feeling of being overwhelmed by what's happening in the memory even though the abuser may be long gone. Example -

2. Repeat Trauma Cycle



*A consequence of his abuse is that my PMS period became a **trigger** for me, becoming very volatile when it occurs at Easter-time. Times of paranoia, vividly relived **flashbacks**, irritability, emotional and sexual frigidity. [**response**] My vagina was conditioned into being hyper-vigilant towards anything that tried to enter it - be it a penis, a doctor's speculum, or my own fingers. Soon as it knows something is going to try and invade it, my vaginal muscles will tighten up as hard as the rock covering Jesus' tomb to keep intruders out. Making intercourse and my yearly pelvic exam extremely painful with occasional tearing and bleeding (even though physically my vaginal opening has the capacity to stretch pretty wide, as evidenced when I gave birth vaginally to a nine pound baby). Anyways, I always feel **overwhelmed** until my period arrives and the cycle is over for another month.*

So here I am today, forty years old and still triggering at Easter time. My best friend's father has been a dead skeleton decomposing in the ground for the past twenty-three years. But the couple days before my period, he'll come to mind as clear as if he were resurrected. And because my cycle is anywhere from four to six weeks, if my PMS is dragging, sometimes I have to rape myself to a flashback in order to get my period to start and find relief from the memories. That sounds strange and sick, raping myself (meaning I masturbate to a memory of him raping me), and it is. But it's also a coping skill though it plays into, reinforces the pattern (which I just now realized while typing so I'll be bringing a copy of this article to my next counseling session). And PMS at Easter-time is the worst.

I've lost boyfriends because of this. Even though they knew my trauma history, they didn't understand why at Easter time I would become emotionally cold and extremely standoffish towards them, flinching if they even came near me. Not just

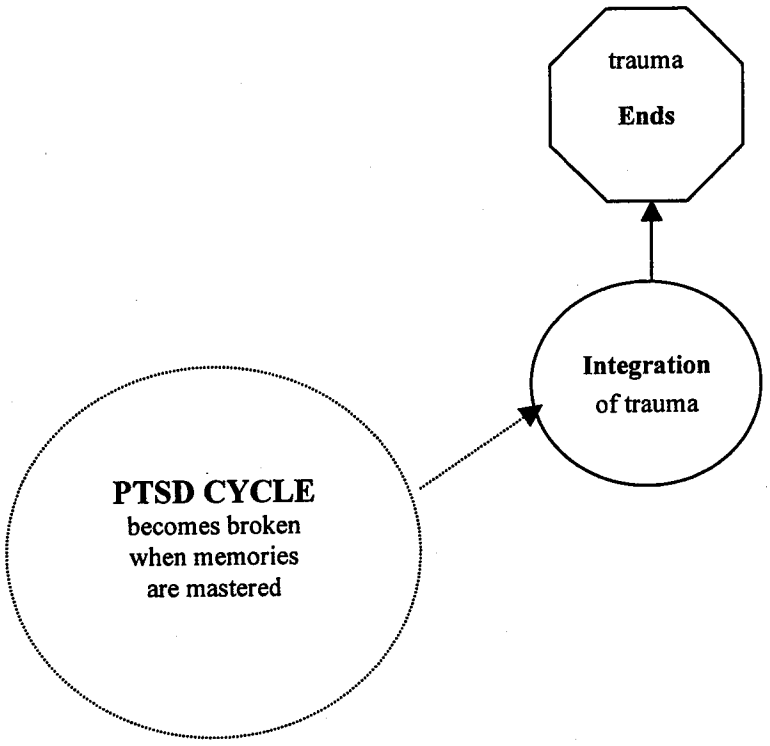
men, but women too haven't understood why I get so paranoid and on edge just before my period. Some women also have disrespected my expressed need to keep their distance at certain times and have touched me after I repeatedly asked them not to. Male or female, when I say don't touch me I mean it and if they do anyways, it's like fingernails on a chalkboard and a potential friendship is broken by distrust.

Some professionals and peers have said, "Well, that happened over twenty years ago. He's dead. Get over it."

I wish it were that easy. One of the rotten things I've found out in my recovery process is that finding out the source of my problem doesn't always make it go away. For this trauma incident, there is more work to be done because of the deep impact it's had on me for over half of my life. As I continue to chip away at different aspects of its effects, I still have hope that at some point there will be an end to all the trauma-reactions related to what he did and he'll finally stay dead in his grave.

3. Trauma Closure Pattern

For the PTSD cycle to become broken, some type of mastery over the memories occurs, leading to an integration of the trauma where the brain becomes unstuck and is able to put the past back into the past where it belongs. This integration process may only need to occur once, or a number of times depending on how many different ways the trauma has affected the person. There is also no one set way to master the memory as different things work for different people, whether it's through education, therapy, medication, external removal of a trigger (see example below), time and maturity, or something else. Example -



Back in 1981 when I was twenty, outside a Job Service center I'd just left after filling out an application, I was approached by a strange young man who tried to coerce me to go with him to do drugs and have sex. Fortunately, there where a lot of people on the busy, city street and it was broad daylight. To finally get away from him, I ducked into a public library. He followed me in and though he kept his

distance, he kept watching me so that I didn't feel safe leaving the library. Because he hadn't actually done anything, I didn't believe I could approach library staff or security about him. So I called my dad, told him I was lost, and asked if he could come pick me up (for ACOA reasons I didn't feel safe telling him the truth). He was pissed but came anyways and I left the library with my dad, the strange man glaring at me from behind a book stack.

I dealt with the trauma situation without getting attacked but for years afterward, whenever I would see a white, cube-shaped Job Service building I would flashback to that moment and break out into a cold sweat. I would be so overwhelmed by the trauma memory that I never went back to that Job Service center in Green Bay and couldn't enter the ones in Elkhorn or Madison either when I was living in those areas and looking for work years later.

Talking over the incident with a therapist and taking a Chimera self-defense course helped me master the memory so it no longer had a hold on me. My brain integrated the event by accepting that even though I could have dealt with the situation better by telling library staff anyways (guilt feelings of "did he go after someone else?") or my father the truth (anger feelings because I didn't feel safe being honest based on my ACOA childhood experiences with him), I dealt with it the best I could at that time considering my background and learned coping skills. Thus, the trauma ended.

The eventual demolishing of the cube-shaped Job Service buildings (as they moved into more generic-looking business buildings) also helped break the PTSD cycle by removing my visual trauma trigger. Today, I have no problem entering the Job Center on Aberg Ave. (which is good since I'm currently unemployed and in need of their different services and programs).

In conclusion, I want to bring up how my unresolved trauma from my teen years has affected my daughter's life. My daughter was born on Good Friday, and I brought her home on Easter. Next year, her golden birthday falls on Easter Sunday. It would be nice to say that her birthday erased the PTSD but it didn't. In fact, she fell victim to one of my PTSD episodes when she was five so that now she lives in long-term foster care and I can only have supervised visits with her. I repeated on her the abuse done on to me by my best friend's father and though that might explain why I did it, it doesn't excuse that I did it. Now I am a PTSD trigger for my daughter who has a pattern of stressing out whenever she sees me, no matter how well the visit goes. I accept full blame for her reactions because he didn't do it, I did. I also accept the consequences, like losing my job last September because of what I did to her six years ago, and only getting to see her a couple times a year, when she's ready for a visit.

In the meantime, I go to parenting classes and support groups, actively participate in counseling and my daughter's monthly team meetings, and call the social workers every week. And continue to advocate for something - classes or support groups or treatment programs - for women who sexually abuse children

because I know from reading the local papers that I'm not the only one but in going for help, there are self-help books and recovery programs for male perpetrators but not females. For us, there's nothing but footnotes and closed doors, even denial by the system as when I first reported it to Dane County human services and was asked by the intake social worker, "Why are you wasting my time with this?"

Because I wanted help - for me and my daughter - so I'd never do that again and she wouldn't repeat the abuse on to her own or other kids when she grows up. That social worker didn't open the case but fortunately, my daughter told a therapist she was seeing about what happened and a different social worker did open the case. I told the police, therapists, and social workers every detail I remembered. Now my daughter is getting the recovery help she needs to help break both her PTSD cycle and the abuse patterns I passed on to her.

My current therapist is evaluating me to see if I'm a good candidate for EMDR, an eye movement therapy that's been very helpful in providing integration to other people's PTSD symptoms. I hope I qualify. Another hope is that in the next ten years, whenever I finish menopause, my PMS-PTSD pattern will be broken by having that trigger removed. Then Easter can become a time for peaceful renewal, not painful remembrance.

There's a song that goes: "May the circle be unbroken..." but if the circle is warped, by all means break it. Break those wobbly old circles and build healthy new paths with safety exits for when times are tough. Do it for ourselves, our relations with others, and especially our children who deserve a better inheritance than our trauma histories.

ANNA'S STORY: THE EFFECTS OF SEXUAL ABUSE, THE SYSTEM'S FAILURE TO RESPOND AND THE EMERGENCE OF A NEW, TRAUMA-BASED PARADIGM*

From the age of 13 to her recent death at the age of 32, my daughter Anna was viewed and treated by the mental health system as "severely and chronically mentally ill." Communication about who she was, how she was perceived and treated, and how she responded took place through her mental health records. A review of 17 years of these records reveals her being described in terms of diagnoses, medications, symptoms, behaviors, and treatment approaches. She was consistently termed "noncompliant" or "treatment resistant." Initially recorded childhood history was dropped from her later records. Her own insights into her condition were not noted. When she was 22, Anna was reevaluated after a suicide attempt. For a brief period, she was rediagnosed as suffering from acute depression and a form of post-traumatic stress disorder. This was the only time in her mental health career that Anna agreed with her diagnosis. She understood herself not as a person with a "brain disease" but as a person who was profoundly hurt and traumatized by the "awful things" that had happened to her.

What happened to Anna?

Anna was born in 1960, the third of five children, a beautiful healthy baby with a wonderful disposition. At the age of about 2 1/2, she began to scream and cry inconsolably. At age 4, we took her to a child psychiatrist who found nothing wrong with her. When we placed her in nursery school, her problems seemed to lessen.

> That Anna was being sexually abused and traumatized at the time is clear now, verified in later years by her own revelations and by the memories of others. Her memories of abuse by a male babysitter were vivid, detailed, and consistent in each telling over the years. They were further verified by persons close to the perpetrator and his family, one of whom witnessed the perpetrator years later in the act of abusing another child.

Evidence that Anna was betrayed and sexually violated at an even earlier age by another perpetrator, a relative, came to light eventually through the revelations of a housekeeper in whom Anna had confided at the time. She had told this woman that a man "played with her where he wasn't supposed to" and that the man "hurted her." This abuse was kept secret for nearly 30 years. Anna remembered trying to tell us, as a little child, what was happening, but there was no one to hear or respond. When she told me a man "fooled" with her, I assumed she meant a young neighborhood boy and cautioned his parents. When we took her to a physician, she experienced the physical examination as yet another violation: "I remember the doctor you took me to

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when I told you. He did things to me that were disgusting (pointing to her genital area)."

The trauma Anna experienced was then compounded by the silence surrounding it. She tried to communicate with her rage, her screams, and her terror. She became the "difficult to handle" child. Her screaming and crying was frequently punished by spankings and confinement to her room. No one then could see or hear her truth; sexual abuse did not "exist" in our minds. When later, as a young girl, she withdrew within herself, somehow different and apart from her peers, we attributed it to her artistic talent or independent personality. We did not see or attend to the terror, dissociation, loneliness, and isolation expressed in her drawings, nor did we heed the hints of trouble expressed by her behaviors. Two grade school psychologists were alone among the professionals we encountered in sensing the turbulence underneath her silence. "Anna is confused about her sexual identity," one reported. "You must help her." The other wrote, "It would seem that Anna has suppressed or repressed traumatic incidents."

Chaos and parental conflict existed in Anna's family from the age of 11 to 13. Although her four brothers and sisters survived the multiple geographic moves, alternative lifestyles, disintegration of their parents' marriage, and episodic violence and alcoholism, Anna did not. She "broke" at age 13. A psychiatrist prescribed Haldol to "help her sleep." She suffered a seizure in reaction, requiring emergency hospitalization. Thus was she introduced to the mental health system.

Anna's invisibility in the mental health system.

Anna was a client of the mental health system for 19 years, until the age of 32. For nearly 12 of those years, she was institutionalized in psychiatric hospitals. When in the community, she rotated in and out of acute psychiatric wards, psychiatric emergency rooms, crisis residential programs, and locked mental facilities. Principle diagnoses found in her charts included borderline personality with paranoid and schizo-typical features, paranoia, undersocialized conduct disorder aggressive type, and various types of schizophrenia including paranoid, undifferentiated, hebephrenic, and residual. Paranoid schizophrenia was her most prominent diagnosis. Chronic with acute exacerbation, subchronic, and chronic courses of schizophrenia were identified. Symptoms of anorexia, bulimia, and obsessive compulsive personality were also recorded. Treatments included family therapy; vitamin and nutritional therapy; insulin and electroconvulsive therapy; psychotherapy; behavioral therapy; art, music, and dance therapies; psychosocial rehabilitation; intensive case management; group therapy; and every conceivable psychopharmaceutical treatment including Clozaril. The use of psychotropic drugs comprised 95% of the treatment approach to her. Although early on there were references to dissociation, her records contain no information about or attempts to elicit the existence of a history of early childhood trauma.

> Anna was 22 when she learned, through conversation with other patients who had also been sexually assaulted as children, that she was not "the only one in the world." It was then that she was first able to describe to me the details of

her abuse. This time, with awareness gained over the years, I was able to hear her.

Events finally became understandable. Sexual torture and betrayal explained her constant screaming as a toddler, her improvement in nursery school, and the reemergence of her disturbance at puberty. It explained the tears in her paintings, the content of her "delusions," her image of herself as shameful, her self-destructiveness, her involvement in prostitution and sadistic relationships, her perception of the world as deliberately hurtful, her isolation, and her profound lack of trust. I thought with relief and with hope that we now knew why treatment had not helped. Here at last was a way to understand and help her heal.

The reaction of the mental health system was to ignore this information. When Anna or I would attempt to raise the subject, a look would come into the professionals' eyes as if shades were being drawn. If notes were being taken, the pencil would stop moving. We were pushing on a dead button. This remained the case until she took her life, 10 years and 15 mental hospitals later.

Believing herself to be "bad," "disgusting," and "worthless," as child sexual abuse victims often do, she hurt, mutilated, and repeatedly revictimized herself. She put cigarettes out on her arms, legs, and genital area; bashed her head with her fists against walls; cut deep scars in herself with torn-up cans; stuck hangers, pencils, and other sharp objects up her vagina; swallowed tacks and pushed pills into her ears; attempted to pull her eyes out; forced herself to vomit; dug her feces out so as to keep food out of her body; stabbed herself in the stomach with a sharp knife; and paid men to rape her.

Again and again, as victims of sexual assault often do, Anna sought relief through suicide. She tried to kill herself many times-slashing her wrists, attempting to drown herself, taking drug overdoses, poisoning herself by spraying paint and rubbing dirt into self-inflicted wounds, slitting her throat with a too-dull razor, and hanging herself from the pipes of a state hospital. Many of the mental health professionals she encountered were highly skilled in their disciplines. Many genuinely cared for Anna, and some grew to love her. But in spite of their caring, her experience with the mental health system was a continuing reenactment of her original trauma. Her perception of herself as "bad," "defective," a "bad seed," or an evil influence on the world was reinforced by a focus on her pathologies, a view of her as having a diseased brain, heavy reliance on psychotropic drugs and forced control, and the silence surrounding her disclosures of abuse.

Just 4 days after her 32nd birthday, after another haunted sleepless night, she hung herself, by her T-shirt, in the early morning bleakness of her room in a California state mental hospital. She was found by a team of three night staff who were on their way in to give her another shot of medication.

The wall of silence.

The tragedy of Anna's life is replicated daily in the lives of many individuals viewed as "chronically and severely mentally ill." Unrecognized and untreated for their childhood trauma, they repeatedly cycle through the system's most expensive psychiatric emergency, acute inpatient, and long-term institutional services. Their disclosures of sexual abuse are discredited or ignored. As happened during their early childhood, they learn within the mental health system to keep silent.

Clinicians who acknowledge the prevalence of traumatic abuse and recognize its etiological and therapeutic significance are deeply frustrated at being denied the tools and support necessary to respond adequately. Sometimes, as Anna's psychologist did, these clinicians leave the mental health system entirely, deciding they can no longer practice with integrity within it.

The biological paradigm = the inability to see.

Although rehabilitative, psychotherapeutic, and self-help approaches operate within the system, the dominant paradigm within which these approaches are subsumed is clearly that of biological psychiatry. Thomas Kuhn, in his analysis of the history and development of the natural sciences, brought the concept of "paradigm" into popular usage. He viewed paradigms as the conceptual networks through which scientists view the world. Data that agree with the scientists' conceptual network are seen with clarity and understanding. But unexpected "anomalous" data that do not match the scientific paradigm are frequently "unseen," ignored, or distorted to fit existing theories.

In the field of mental health, a biologically-based understanding on the nature of mental illness has for years been the dominant paradigm. It has determined the appropriate research questions and methodologies; the theories taught in universities and applied in the field; the interventions, treatment approaches, and programs used; and the outcomes seen to indicate success.

Paradigmatically understood, the mental health system was constructed to view Anna and her "illness" solely through the conceptual lens of biological psychiatry. The source of her pain, early childhood sexual abuse trauma, was an anomaly—a contradiction to the paradigm—and, as such, could not be seen through this lens. Her experience did not match the professional view of mental illness. It did not fit within the system's prevailing theoretical constructs. There was no adequate language available within the professions to articulate or label it. There were not reimbursement mechanisms to cover its treatment. It was not addressed in curricula for professional training and education, nor was there support for research on the phenomenon. There were no tools—treatment, rehabilitation, or self-help interventions-for responding to it. And there was no political support within the field for its inclusion. Screened through the single lens of the biological paradigm, Anna's experience could not be assimilated. It had to be unseen, rejected, or distorted to fit within the parameters of the accepted conceptual framework.

As a result of this paradigmatic blindness, conventionally accepted psychiatric practices and institutional environments repeatedly retraumatized Anna, reenacting and exacerbating the pain and sequelae of her childhood experience.

The emerging trauma paradigm.

Although paradigm shifts mark the way to progress and opportunity, they are always resisted initially. They cause change, disrupt the status quo, create tension and uncertainty, and involve more work. Resistance to a sexual abuse trauma paradigm has existed for more than 130 years, during which time the etiological role of childhood sexual violation in mental illness has been alternately discovered and then denied. In 1860, the prevalence and import of child sexual abuse was exposed by Amboise Tardieu, in 1896 by Sigmund Freud, in 1932 by Sandor Ferenczi, and in 1962 and 1984, by C. Henry Kempe. Each exposure was met by the scientific community with distaste, rejection, or discreditation. Each revelation was countered with arguments that in essence blamed the victims and protected the perpetrators. Freud, faced with his colleagues' ridicule of and hostility to his discoveries, sacrificed his major insight into the etiology of mental illness and replaced his theory of trauma by the view that his patients had "fantasized" their early memories of rape and seduction. Today, 100 years later, in spite of countless instances of documented abuse, this tradition of denial and victim blame continues to thrive.

Psychiatrist Roland Summit refers to this denial as "nescience" or "deliberate, beatific ignorance." He proposes that "in our historic failure to grasp the importance of sexual abuse and our reluctance to embrace it now, we might acknowledge that we are not naively innocent. We seem to be willfully ignorant, 'nescient'".

At this point in history, however, multiple and divergent forces are confronting nescience with truth. Although these forces will continue to meet resistance, they appear to be forming a powerful movement that will help to protect children from adult violation and will promote acceptance of a trauma-based paradigm recognizing the pain of individuals like my daughter and offering them "the radical prospect of recovery".

K'S STORY[*]

The process of claiming my own sense of personal power has been a slow one. Even though I have been living with acute PTSD for at least the last 10 years, it wasn't until eight years ago that I finally began to make some positive steps forward.

The first step in regaining my own sense of personal power was in choosing a therapist. Until that time I was in a chronic state of crisis, I had had a series of therapists and psychiatrists who treated me as if I had borderline personality disorder. This diagnosis, in turn, determined what services were offered to me as well as the attitudes of those who offered them. I was told I could not contact my therapist by phone outside of office hours. So my crises went unresolved until they were acute enough to require hospitalization every three to four weeks. This, because of my borderline diagnosis, was deemed to be inappropriate use of the hospital and a new treatment plan which strictly limited my use of the hospital was drawn up. Part of the treatment plan involved using crisis homes in place of the hospital. I willingly went along with the treatment plan, knowing that resisting would only strengthen their resolve to treat me as a borderline. But there was a problem with crisis homes too. It seemed I over-utilized them just like the hospital and as a result limits were placed on my use of the crisis home. With each limitation that was put on me, I went into a deeper state of crisis because my needs were not being addressed.

In choosing a new therapist I knew only one thing. I needed a therapist whose sense of reality I could trust and who could avoid a power struggle with me at all costs. My connection with reality felt fairly tenuous and I needed someone who could help me stay grounded while teaching me how to trust myself. In terms of power struggles, I had been locked into them on several fronts: with my previous therapists and psychiatrists over my diagnosis; and, with the hospital and crisis home people over the frequency of my stays. I knew I couldn't take much more. I knew that the final power struggle would result in me taking my own life. Finding a new therapist was probably the smartest move I've made in the past ten years, because out of that relationship I learned to trust myself and reclaim my power.

The next step, one instigated by my new therapist, was to redefine the hospital and crisis home treatment plans. It took time and it was scary, but with her help we were able to reframe for my care providers my use of the hospital and crisis homes. With my new therapist the diagnosis of borderline personality disorder was discarded and replaced with PTSD/major depressive disorder. And instead of limiting use of hospital and crisis homes to once per month, an arrangement that was more suited to the caregiver's convenience than my own needs, we set things up so that I could use the hospital as needed. I began to feel like I would be supported in a crisis rather

[*] Anonymous (2002). Written for the *New Partnerships for Women Consumer Curriculum*. Author has asked that her story not be reprinted.

than abandoned and surprise of surprises, the amount of time I spent in crisis markedly decreased.

Finally there was the diagnosis of borderline. I discovered as a result of a routine staffing in a day treatment program, that the hated diagnosis was still on some of my records. I was crushed and angry. I had worked hard, had made many changes and assumed greater and greater responsibility for myself and I was still being followed around by this diagnosis. People were no longer treating me as a borderline, but just the fact that it still occupied space on my records was unacceptable. So I confronted my psychiatrist, who had filled out the form. I did so as respectfully as possible, recounting for him my many changes and improvement and he responded by apologizing. He redid the paperwork and the word borderline was removed. This may seem like a technicality, but to me it meant a lot - it meant that my progress was recognized and appreciated.

Probably the most important thing I have learned in the past eight years is to surround myself with supportive trustworthy people and to listen to my gut. It is definitely a learning process, one in which I am still engaged. I was not raised to do either of those things but they are definitely skills that can be learned at any age.

A COUPLE OF BARB'S STORIES*

Sometimes the very people we go to for help hurt us even more. Once, when I had cut myself pretty badly I went to the E.R. to get stitches. I had lost quite a bit of blood and since cutting myself is not about suicide and I didn't want to get an infection, I went for help. I really didn't want to because getting stitches hurts and by then I was feeling things again. I wasn't feeling when I cut; that was part of the reason I did it. It wasn't a choice, I HAD to cut. Well, when the doctor came in to put in the stitches he told me that he wasn't going to numb my arm because I *liked* pain. I must have fought him because I remember them tying me down. I don't remember much else because I went away somewhere deep inside my head.

For many years people with mental illnesses didn't get even minimal health care so it was a big step forward for hospitals to routinely give physical exams to patients when they were admitted. But sometimes a good thing can go wrong.

Once, when I was admitted to the state hospital, they told me I had to have a physical, given by a med student from the UW. I agreed because I was too depressed to argue with them but I told them I couldn't let them do a pelvic exam. Now I'm crazy, not stupid, and I know the importance of PAP smears etc. but as an abuse survivor I can't handle that. They said I had no choice. I said NO! They told me I would have to stay in seclusion (with no clothes on, suicide precautions) until I had the exam. They said I couldn't be with the other patients because I could have a contagious disease. Well, I could have been in seclusion for a very long time. I knew they would win so I said I would try. I did try. But during the exam he hurt me and I freaked out. He was sitting on one of those little three-legged stools with wheels and I planted my foot in the middle of his chest and sent him flying into the wall. I didn't do it on purpose, I just reacted. Well then they put me in seclusion for being violent. I got so depressed I stopped eating, talking, even moving. Eventually they forced me out of the seclusion room and locked me out so I had to be with the other patients. Eventually, I got *better* and went home.

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* Barbara Hennings, NPW and Yahara House (2002). Written for the *New Partnerships for Women Consumer Curriculum*. Author grants permission to reprint this article. Citation of the source is appreciated.

AN OUTRAGE OF INSTITUTIONS*

What can happen to a person when they are institutionalized and abused within a controlled setting where there is no way to report abuse because the abusers are the people who are supposed to be the protectors? A woman was raped in jail and had no known way to report the incident because the people who raped her were the deputies themselves. This happened too many times to count, and the woman woke up bruised and naked and didn't know where to turn. The only people she could turn to were the deputies and they were the ones who did it. The woman kept telling her lawyer she woke up in the cell naked, yet he would not believe any story the woman told him. She had nowhere to turn and did not know how to call out for help. The message she was given was violence was okay by the very officers who are supposed to protect her. Her faith in the police system was broken: the woman was shattered and torn, and these memories forever became a part of the woman's nightmares. This is institutionalization at its worst possible outcome.

The experience shaped this woman's future existence into a scared, frightened, victim of Post-Traumatic Stress. She can still overcome, as have many victims of Criminal Justice Systems in many countries that have outcomes of tortured prisoners and victims that for years are too afraid to come forward.

The sun shines today and what does this woman say? She can be strong for she is a survivor. She can speak out for she is a speaker. She can say she refuses to be abused. She is woman, she is strong. This will only prove us to be strong.

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