National Association of Case Management
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Mezzanine A

"Mental Health Consumers Surviving Trauma"

by

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This presentation will be up on the web within two weeks at:

http://home.att.net/~parisser

What is Trauma?

In common, everyday language usage,

"trauma"

simply means

a highly stressful event.

PTSD =
Post Traumatic STRESS Disorder

Stress = any change
Eustress = positive stress
Distress = negative stress

Three ways to cope with stress:

1) **Learn to control the amount of stress coming into the system (vessel)**

2) **Learn to let stress out of the system (vessel)**

3) **Build the walls of the vessel higher in order to be able to handle more stress**

In Criteria for Building a Trauma-Informed Mental Health Service System, NASMHPD adopted this definition:

"Trauma is interpersonal violence, over the life span, including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism, and disasters."

Psychological trauma is the unique individual experience of an event or enduring conditions, in which:

1. The individual's ability to integrate his/her emotional experience is overwhelmed,

or

2. The individual experiences (subjectively) a threat to life, bodily integrity, or sanity.

The definition of trauma includes responses to powerful **one-time incidents** like accidents, natural disasters, crimes, surgeries, deaths, and other violent events.

It also includes responses to **chronic or repetitive experiences** such as child abuse, neglect, combat, urban violence, concentration camps, battering relationships, and enduring deprivation.

This definition *intentionally* does not allow ***us*** to determine whether a particular event is traumatic; that is up to each survivor.

This definition provides a guideline for our understanding of a survivor's experience of the events and conditions of his/her life.

There are two components to a Traumatic Experience:

1) Objective
2) Subjective

It is the subjective experience of objective events that constitutes trauma.

The more you believe you are endangered, the more traumatized you will be.

In other words,

TRAUMA

is defined by the
***experience of the survivor*.**

Those at risk for developing PTSD include, anyone who has been victimized or has witnessed a violent act, or who has been repeatedly exposed to life-threatening situations.

This includes survivors of:

- Domestic or intimate partner violence
- Rape or sexual assault or abuse
- Physical assault such as mugging or carjacking
- Other random acts of violence such as those that take place in public, in schools or in the workplace
- Children who are neglected or sexually, physically or verbally abused, or adults who were abused as children

This also includes survivors of unexpected events in everyday life such as:

- Car accidents or fires
- Natural disasters, such as tornadoes or earthquakes
- Major catastrophic events such as a plane crash or terrorist attack
- Disasters caused by human error, such as industrial accidents
- Combat veterans or civilian victims of war
- Those diagnosed with a life-threatening illness or who have undergone invasive medical procedures
- Professionals who respond to victims in trauma situations, such as, emergency medical service workers, police, firefighters, military, and search and rescue workers
- People who learn of the sudden unexpected death of a close friend or relative

Estimated risk for developing PTSD for those who have experienced the following traumatic events:

- Rape (49 %)
- Severe beating or physical assault (31.9 %)
- Other sexual assault (23.7 %)
- Serious accident or injury, for example, car or train accident (16.8 %)
- Shooting or stabbing (15.4 %)
- Sudden, unexpected death of family member or friend (14.3 %)
- Child's life-threatening illness (10.4 %)
- Witness to killing or serious injury (7.3 %)
- Natural disaster (3.8 %)

Trauma Prevalence: Community Samples

- National Comorbidity Survey: 61% of **men** (51% of women) reported at least one traumatic event
- Detroit Area Survey of Trauma: approximately 90% lifetime exposure; **men** reported 5.3 traumatic events (4.3 for women)
- Other community studies consistent with these: trauma is pervasive, not rare

In the United States, a child is reported abused or neglected every 10 seconds (6 per minute = 360 every hour = 8,640 every day = 60,480 every week = 259,200 every month = 3,144,960 every year).

In the U.S. about one in three girls and one in five boys are sexually abused before they reach adulthood. About one in three women and one in eight men are raped after turning 18.

People of all ages have been raped—from newborn infants to people in their 90s.

Those most likely to be raped are those people who have less power in society, such as people who are disabled, non-white, female, new to the school or community, and so on.

Approximately 1.5 million adult women and 835 thousand men are raped and physically assaulted by an intimate partner each year.

Roughly 4% to 6% of our elderly are abused, primarily by family members.

Seventy percent of women who are homeless were abused as children. Nearly 90% of women who are both homeless and have a mental illness experienced abuse both as children and adults.

Eighty percent of incarcerated women have been victims of physical and sexual abuse. The majority of murderers and sexual offenders, who tend to be male, have a history of childhood maltreatment.

The majority of both men and women in substance abuse programs report childhood abuse or neglect. Each year, more than a half-million women injured by their intimate partners require medical treatment.

Each year, 2,000 children die from maltreatment: 90% are under the age of five.

Trauma is often categorized in the following ways:

Single Blow vs. Repeated Trauma

and

Natural vs. Human Made

Abuse is often categorized in two ways:

Acts of Omission

Psychological Neglect – Sustained parental nonresponsiveness and psychological or physical unavailability, such that the child is deprived of normal psychological stimulation, soothing, contact comfort, nurturance, love and support.

Acts of Commission

Actual abusive behaviors directed toward the child. These acts, whether physical, sexual, or psychological, can produce longstanding interpersonal difficulties, as well as distorted thinking patterns, emotional disturbance, and posttraumatic stress.

When such acts occur early in life, they are especially likely to motivate the development of avoidance strategies that allow the child to function despite inescapable emotional pain.

Faced with parental violence, the child may develop a style of relating whereby he or she psychologically attenuates or avoids certain attachment interactions with a given abusive caretaker.

Although this defense protects the child, to some extent, from overwhelming distress and distorted environmental input, it also tends to reduce his or her access to any positive attachment stimuli that might be available in the environment.

This response, in turn, further deprives the child of normal attachment-related learning and development, reinforces avoidance as a primary response style, and may partially replicate the difficulties associated with neglect-related attachment deprivation.

Single Blow vs. Repeated Trauma

Single shocking events:

* *Natural disasters*
* *Technological disaster*
* *Criminal violence*

Unfortunately, traumatic effects are often **cumulative**:

As traumatic as single-blow traumas are, the traumatic experiences that result in the most serious mental health problems are prolonged and repeated, sometimes extending over years of a person's life.

Natural vs. Human Made

Prolonged stressors, deliberately inflicted by people, are far harder to bear than accidents or natural disasters. Most people who seek mental health treatment for trauma have been victims of violently inflicted wounds dealt by a person. If this was done deliberately, in the context of an ongoing relationship, the problems are increased. The worst situation is when the injury is caused deliberately in a relationship with a person on whom the victim is dependent – most specifically a parent-child relationship.

Varieties of Man-Made Violence

* *War/political violence/terrorism*
* *Human rights abuse*
* *Criminal violence*
* *Rape*
* *Domestic Violence*
* *Child Abuse*
* *Sexual abuse*
* *Emotional/verbal abuse*
* *Witnessing*
* *Sadistic abuse*

Research shows that about 1/3 of sexually abused children have no symptoms, and a large proportion that do become symptomatic, are able to recover. Fewer than 1/5 of adults who were abused in childhood show serious psychological disturbance.

http://www.acestudy.org/

What is the ACE Study?

The ACE Study is an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente. Led by Co-principal Investigators Robert F. Anda, MD, MS, and Vincent J. Felitti, MD, the ACE Study is perhaps the largest scientific research study of its kind, analyzing the relationship between multiple categories of childhood trauma

Adverse Childhood Experiences (ACEs), and health and behavioral outcomes later in life.

What's an ACE?

Growing up experiencing any of the following conditions in the household prior to age 18:

1. Recurrent physical abuse
2. Recurrent emotional abuse
3. Contact sexual abuse
4. An alcohol and/or drug abuser in the household
5. An incarcerated household member
6. Someone who is chronically depressed, mentally ill, institutionalized, or suicidal
7. Mother is treated violently
8. One or no parents
9. Emotional or physical neglect

http://www.ajpm-online.net/article/PIIS0749379798000178/abstract
Volume 14, **Issue 4**, Pages 245-258 (May 1998)

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study

Vincent J Felitti MD, FACPA, Robert F Anda MD, MSB, Dale Nordenberg MDC, David F Williamson MS, PhDB, Alison M Spitz MS, MPHB, Valerie Edwards BAB, Mary P Koss PhDD, James S Marks MD, MPHB

Background: The relationship of health risk behavior and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse, and household dysfunction during childhood has not previously been described.

Methods: A questionnaire about adverse childhood experiences was mailed to 13,494 adults who had completed a standardized medical evaluation at a large HMO; 9,508 (70.5%) responded. Seven categories of adverse childhood experiences were studied: psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The number of categories of these adverse childhood experiences was then compared to measures of adult risk behavior, health status, and disease. Logistic regression was used to adjust for effects of demographic factors on the association between the cumulative number of categories of childhood exposures (range: 0–7) and risk factors for the leading causes of death in adult life.

Results: More than half of respondents reported at least one, and one-fourth reported ≥2 categories of childhood exposures. We found a graded relationship between the number of categories of childhood exposure and each of the adult health risk behaviors and diseases that were studied ($P < .001$).

Persons who had experienced four or more categories of childhood exposure, compared to those who had experienced none, had **4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking, poor self-rated health, ≥50 sexual intercourse partners, and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity**. The number of categories of adverse childhood exposures showed a graded relationship to the presence of adult diseases including **ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.** The seven categories of adverse childhood experiences were strongly interrelated and persons with multiple categories of childhood exposure were likely to have multiple health risk factors later in life.

Conclusions: We found a strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.

http://www.psychservices.psychiatryonline.org/cgi/content/abstract/58/2/245
Psychiatr Serv 58:245-253, February 2007

Correlates of Adverse Childhood Events Among Adults With Schizophrenia Spectrum Disorders

Stanley D. Rosenberg, Ph.D., Weili Lu, Ph.D., Kim T. Mueser, Ph.D., Mary Kay Jankowski, Ph.D. and Francine Cournos, M.D.

OBJECTIVE: Multiple studies have found that childhood adversity is related to a range of poor mental health, substance abuse, poor physical health, and poor social functioning outcomes in the general population of adults. However, despite the high rates of childhood adversity in schizophrenia, the clinical correlates of these events have not been systematically evaluated. This study evaluated the relationship between adverse experiences in childhood and functional, clinical, and health outcomes among adults with schizophrenia.

METHODS: The authors surveyed 569 adults with schizophrenia regarding adverse childhood events (including physical abuse, sexual abuse, parental mental illnesses, loss of a parent, parental separation or divorce, witnessing domestic violence, and foster or kinship care). The relationships between cumulative exposure to these events and psychiatric, physical, and functional outcomes were evaluated.

RESULTS: Increased exposure to adverse childhood events was strongly related to psychiatric problems (suicidal thinking, hospitalizations, distress, and posttraumatic stress disorder), substance abuse, physical health problems (HIV infection), medical service utilization (physician visits), and poor social functioning (homelessness or criminal justice involvement).

CONCLUSIONS: The findings extend the results of research in the general population by suggesting that childhood adversity contributes to worse mental health, substance abuse, worse physical health, and poor functional outcomes in schizophrenia.

More disturbance is associated with
more severe abuse:

. longer duration,
. forced penetration,
. helplessness,
. fear of injury or death,
. perpetration by a close relative or caregiver,

coupled with lack of support or negative consequences from disclosure.

Elements of the traumatic experience:

- May be an isolated event or prolonged and repetitious
- Will have different impact depending upon the age and circumstance of the victim
- Are more likely to produce harm if they threaten life or bodily integrity
- Are more likely to produce harm if the person is exposed to extreme violence or death
- Are more likely to produce harm if the person is trapped, taken by surprise, or exposed to the point of exhaustion
- May include active victimization, coerced witnessing of atrocity, coercion to participate in the victimization of others
- The specific characteristics are important:
    - loss of control
    - helplessness
    - unpredictability
    - arbitrary or inconsistent rules
    - invasiveness
    - isolation
    - constant terror
    - blaming the victim
    - periods of remorse or special treatment from perpetrator

Psychological effects are likely to be most severe if the trauma is:

1. Human caused
2. Repeated
3. Unpredictable
4. Multifaceted
5. Sadistic
6. Undergone in childhood
7. And perpetrated by a caregiver

Other possible effects of trauma

Triggering and retraumatization

Damage to faith and spiritual groundedness

Loss of trust in others

Anger

Difficulty modulating intimacy

Feelings of alienation and disconnectedness from others

Suicidality

Self-mutilation

Extreme shame and guilt

Psychiatric Model (deficit based)	Observed Behavior	Trauma Paradigm (adaptive survival)
"manipulation"	Person asks indirectly to have needs met, usually by changing interpersonal environment.	Abuser will often deny overt requests; person has learned to adapt to get needs met.
Self-mutilation	Person engages in injurious behavior in order to feel pain, feel real, punish self.	Pain often stops dissociation, de-personalization, or de-realization associated with PTSD.
Suicidality	Attempts to kill self accompanied by expression of hopelessness, rage, intense pain, feeling out of control.	Person feels need to take charge of pain/fate/life in a definitive way.
"Splitting"	1. Person sees the world, especially relationships, in the extreme ("black and white thinking"). 2. Person asks one person after another for what s/he needs.	1. Person has learned from abuse relationship to expect unpredictable extremes (e.g., violence or neglect alternating with indulgence). 2. This is self-advocacy, a *strength*.

Psychiatric Model (deficit based)	Observed Behavior	Trauma Paradigm (adaptive survival)
"Drug-seeking" and substance abuse	Person requests benzodiazepines or stimulants, or uses alcohol and street drugs.	Person seeks relief from autonomic hyper-arousal and psychological symptoms of PTSD.
Intense Emotion: Rage, Fear, Mood Swings	Responses seem to be extreme or unexplained by present events or situations.	Current situation triggers PTSD symptoms of flashbacks, reliving of emotional aspects of trauma, autonomic hyper-arousal, "repetition compulsion."
Self-defeating behavior and "Impulsivity"	Person helplessly or defiantly continues behaviors or makes choices that undermine her goals or expose her to risk.	"Repetition compulsion;" may also reflect a symbolic demonstration of strength, courage, or control.
"Dependency"	Person attaches desperately to helpers as if life is very dangerous and precarious.	Abuse milieu is extremely dangerous, unpredictable, may be life-threatening; person may have been exposed to threats or reality of abandonment; person may have adaptively learned to hang on to positive relationships.

Psychiatric Model (deficit based)	**Observed Behavior**	**Trauma Paradigm (adaptive survival)**
"Blaming"	Person is unclear about attributing responsibility; person holds others responsible for his internal state.	Abuse relationship may have exposed person to blame for the abuse ("You asked for it.") or blame for other things out of his control or the abuse-apology cycle; no early role models of interpersonal accountability; may trigger feelings that abuser *is* the source of the distress.

Surviving the Violence

Common Reactions to the Stress of Trauma

Survivors of physical, sexual, or verbal abuse often experience several of the following:

- Disassociation
- Intellectualization/rationalization
- Minimization of events
- Depression
- Severe anxiety
- Confused thinking
- Lowered concentration
- Memory impairment
- Trouble sleeping
- Flashbacks
- Migraines
- Chest pains or heart palpitations
- Suicidal thoughts
- Self harm behaviors or fantasies
- Trying to be "perfect"
- Isolating/avoiding people
- Nightmares
- Inability to talk about event
- "Acting out"
- Emotional numbness
- Denial
- Feeling overwhelming emotions (panic, rage, depression, grief, shock)
- Increase in heart rate and blood pressure, fast breathing, clammy hands or feet, etc.
- Problems with eating behaviors
- Choking sensations
- Pelvic pain
- Fatigue
- Gastrointestinal disorders
- Chronic pain syndromes (Fibromyalgia)
- Self-medication as a coping mechanism (for instance, alcohol or drug use)

The triad of post-traumatic stress disorder

Hyperarousal

Intrusion

Constriction

Hyperarousal

- Hypervigilance
- Irritability
- Extreme startle response
- Insomnia and awakenings
- Sensitivity to environmental intrusions
- Distractibility

Intrusion

Intrusive recall

Flashbacks

Traumatic nightmares

Triggers

Reenactment “repetition compulsion”

Constriction

Perceptual numbing or distortion

Emotional detachment

Passivity or freezing

Depersonalization

Derealization

Dissociation

Substance abuse (75-85% of combat veterans having severe PTSD)

Voluntary suppression of thoughts or withdrawal from others

Suppressed initiative and reduced plans for the future

The PTSD Spectrum and complex PTSD (model by Judith Herman, M.D.)

Subjected to totalitarian control over a prolonged period

Alterations in affect and impulsivity (suicidality, self-injury, depression, anger, sexuality)

Alterations in consciousness (dissociation, depersonalization, amnesia, intrusive memories, flashbacks)

Alterations in self-perception (helplessness, guilt, stigma, alienation)

Alterations in the perception of the perpetrator (idealized, supernatural, power, acceptance of P's belief system)

Alterations in relationships (withdrawal, mistrust, safety, intimacy)

Alteration in spiritual life and meaning (loss of faith, hopelessness)

Trauma among people using psychiatric services

43% of psychiatric inpatients reported physical and/or sexual assault history (Carmen, 1984)

42% of female inpatients of state hospital reported incest (Craine,1988)

52% of consumers in urban psychiatric emergency department reported incest

Actual numbers are uncertain due to differences in how data were collected (chart review vs. interview) - may be as high as 50-70% of female consumers

40-50% of **male** consumers, sexually abused in childhood

Does not include post-traumatic effects associated with poverty, exposure to violence, homelessness, trauma within the mental health system, other life experiences (military), etc.

Adults who were abused during childhood are:

* More than twice as likely to have at least one lifetime psychiatric diagnosis;
* Almost three times as likely to have an affective disorder;
* Almost three times as likely to have an anxiety disorder;
* Almost 2 1/2 times as likely to have phobias;
* More than 10 times as likely to have a panic disorder;
* Almost 4 times as likely to have an antisocial personality disorder.

“Why do we use the language of war rather than the language of love in the human services. For instance we talk about sending staff out into the field to provide front line services to target populations for whom we develop and implement treatment strategies whether they want them or not.”

Pat Deegan, Ph.D., “Spirit Breaking: When the Helping Professions Hurt”

Psychiatry's Traumatizing (and Retraumatizing) Effects

Incarcerates citizens who have committed crimes against neither persons nor property through the involuntary commitment process

Imposes diagnostic labels on people; labels that are often perjorative, stigmatize and defame

Induces proven neurological damage by force and coercion with powerful psychotropic drugs

Stimulates violence and suicide with drugs promoted as able to control these activities

Destroys brain cells and memories with an increasing use of electroshock (also known as electro-convulsive therapy)

Employs restraint and solitary confinement in preference to patience and understanding

Humiliates individuals already damaged by traumatizing assaults to their self-esteem

Teaches learned helplessness through the constant threat of the use of involuntary commitment, force and coercion

Lacks sensitivity to issues of trauma including being unaware or unwilling to address potential "triggers" (Hospitals/offices may have personnel, equipment, smells, procedures, pictures, etc. that might be vivid reminders of past abuse suffered by patients)

Mental health professionals often just don’t listen. They KNOW what's best for the person so they discount the person as being the best expert on their own life so they tune out or don't hear what the person is really saying.

Help From Health Care Providers, Counselors and Groups

You must be in charge of your recovery in every way.
Wherever you go for help, the program or treatment should include the following:

Empowerment–You must be in charge of your healing in every way to counteract the effects of the trauma where all control was taken away from you.

Validation–You need others to listen to you, to validate the importance of what happened to you, to bear witness, and to understand the role of this trauma in your life.

Connection–Trauma makes you feel very alone. As part of your healing, you need to reconnect with others.

Have hope. It is important that you know that you can and will feel better.

Take personal responsibility. When you have been traumatized, you lose control of your life. You may feel as though you still don't have any control over your life. You can begin to take back that control by being in charge of every aspect of your life. Others, including your spouse, family members, friends, and health care professionals will try to tell you what to do. Before you do what they suggest, think about it carefully. Do you feel that it is the best thing for you to do right now? If not, do not do it. You are responsible for your own behavior. Being traumatized is not an acceptable excuse for behavior that hurts you or hurts others.

Talk to one or more people about what happened to you. Telling others about the trauma is an important part of healing the effects of trauma.

Develop a close relationship with another person. You may not feel close to or trust anyone. This may be a result of your traumatic experiences. Part of healing means trusting people again.

Things You Can Do Every Day to Help You Feel Better

There are many things that happen every day that can cause you to feel ill, uncomfortable, upset, anxious, or irritated. You will want to do things to help yourself feel better as quickly as possible, without doing anything that has negative consequences, for example, drinking, committing crimes, hurting yourself, risking your life, or eating lots of junk food.

- **Do something fun or creative,** something you really enjoy, like crafts, needlework, painting, drawing, woodworking, making a sculpture, reading fiction, comics, mystery novels, or inspirational writings, doing crossword or jigsaw puzzles, playing a game, taking some photographs, going fishing, going to a movie or other community event, or gardening.

- **Get some exercise.** Exercise is a great way to help you feel better while improving your overall stamina and health. The right exercise can even be fun.

- **Write something.** Writing can help you feel better. You can keep lists, record dreams, respond to questions, and explore your feelings.

- **Use your spiritual resources.** Spiritual resources and making use of these resources varies from person to person. For some people it means praying, going to church, or reaching out to a member of the clergy. For others it is meditating or reading affirmations and other kinds of inspirational materials.

- **Do something routine.** When you don't feel well, it helps to do something "normal"—the kind of thing you do every day or often, things that are part of your routine like taking a shower, washing your hair, making yourself a sandwich, calling a friend or family member, making your bed, walking the dog, or getting gas in the car.

- **Wear something that makes you feel good.** Everybody has certain clothes or jewelry that they enjoy wearing. These are the things to wear when you need to comfort yourself.

- **Get some little things done.** It always helps you feel better if you accomplish something, even if it is a very small thing. Think of some easy things to do that don't take much time. Then do them. Here are some ideas: clean out one drawer, put five pictures in a photo album, dust a book case, read a page in a favorite book, do a load of laundry, cook yourself something healthful, send someone a card.

- **Learn something new.** Think about a topic that you are interested in but have never explored. Find some information on it in the library. Check it out on the Internet. Go to a class. Look at something in a new way. Read a favorite saying, poem, or piece of scripture, and see if you can find new meaning in it.

- **Do a reality check.** Checking in on what is really going on rather than responding to your initial "gut reaction" can be very helpful. For instance, if you come in the house and loud music is playing, it may trigger the thinking that someone is playing the music just to annoy you. The initial reaction may be to get really angry with them. That would make both of you feel awful.

- **Be present in the moment.** This is often referred to as mindfulness. Many of us spend so much time focusing on the future or thinking about the past that we miss out on fully experiencing what is going on in the present. Making a conscious effort to focus your attention on what you are doing right now and what is happening around you can help you feel better. Look around at nature. Feel the weather. Look at the sky when it is filled with stars.

- **Stare at something pretty or something that has special meaning for you.** Stop what you are doing and take a long, close look at a flower, a leaf, a plant, the sky, a work of art, a souvenir from an adventure, a picture of a loved one, or a picture of yourself. Notice how much better you feel after doing this.

- **Play with children in your family or with a pet.** Romping in the grass with a dog, petting a kitten, reading a story to a child, rocking a baby, and similar activities have a calming effect which translates into feeling better.

- **Do a relaxation exercise.** There are many good books available that describe relaxation exercises. Relaxation tapes that feature relaxing music or nature sounds are available. Just listening for 10 minutes may help you feel better.

- **Take a warm bath.** This may sound simplistic, but it helps. If you are lucky enough to have access to a Jacuzzi or hot tub, it's even better. Warm water is relaxing and healing.

- **Expose yourself to something that smells good to you.** Many people have discovered fragrances that help them feel good. Sometimes a bouquet of fragrant flowers or the smell of fresh baked bread will help you feel better.

- **Listen to music.** Pay attention to your sense of hearing by pampering yourself with delightful music you really enjoy. Libraries often have records and tapes available for loan. If you enjoy music, make it an essential part of every day.

- **Make music.** Making music is also a good way to help yourself feel better. Drums and other kinds of musical instruments are popular ways of relieving tension and increasing well-being. Perhaps you have an instrument that you enjoy playing, like a harmonica, kazoo, penny whistle, or guitar.

- **Sing. Singing helps.** It fills your lungs with fresh air and makes you feel better. Sing to yourself. Sing at the top of your lungs. Sing when you are driving your car. Sing when you are in the shower. Sing for the fun of it. Sing along with favorite records, tapes, compact discs, or the radio. Sing the favorite songs you remember from your childhood.

Sexual abuse – Any **sexually related behavior between two or more people where there is an imbalance of power**. This can include adult-child, older child-younger child, adolescent-younger person, or any situation where the other person is forced to participate. It is sexually abusive when the victim is unaware of the abuse (such as being watched while bathing, using the bathroom, changing, etc.), as well as when the victim is sleeping, unconscious, under the influence of alcohol or drugs, or is too young, naïve, or able to understand what is going on.

Sexual abuse is a misuse or abuse of power and control. It may be accomplished through force, deception, bribery, blackmail, or any other means that gives one party an upper hand.

The behaviors may range from peeping, exposing genitals, fondling, oral/anal/vaginal sex, showing or taking pornographic pictures of a child, or any sexual behavior that is not consensual.

Am J Prev Med. 2005 Jun;28(5):430-8. Links

Long-term consequences of childhood sexual abuse by gender of victim.

Dube SR, **Anda RF**, **Whitfield CL**, **Brown DW**, **Felitti VJ**, **Dong M**, **Giles WH**.

BACKGROUND: Childhood sexual abuse (CSA) is a worldwide problem. Although most studies on the long-term consequences of CSA have focused on women, sexual abuse of both boys and girls is common. Thus, a comparison of the long-term effects of CSA by gender of the victim will provide perspective on the need for future research, prevention activities, and treatment of survivors.

METHODS: A retrospective cohort study was conducted from 1995 to 1997 among 17,337 adult HMO members in San Diego, California. Participants completed a survey about abuse or household dysfunction during childhood, and multiple other health-related issues. Multivariate logistic regression was used to examine the relationships between severity of CSA (intercourse vs no intercourse) and long-term health and social problems (substance use and abuse, mental illness, and current problems with marriage and family) by gender of victim. Models controlled for exposure to other forms of adverse childhood experiences that co-occur with CSA. Among men, the relationship between the gender of the CSA perpetrator to the outcomes was also examined.

RESULTS: Contact CSA was reported by 16% of males and 25% of females. Men reported female perpetration of CSA nearly 40% of the time, and women reported female perpetration of CSA 6% of the time. CSA significantly increased the risk of the outcomes. The magnitude of the increase was similar for men and women. For example, compared to reporting no sexual abuse, a history of suicide attempt was more than twice as likely among both men and women who experienced CSA ($p<0.05$). Compared with those who did not report CSA, men and women exposed to CSA were at a 40% increased risk of marrying an alcoholic, and a 40% to 50% increased risk of reporting current problems with their marriage ($p<0.05$).

CONCLUSIONS: In this cohort of adult HMO members, experiencing CSA was common among both men and women. The long-term impact of CSA on multiple health and social problems was similar for both men and women. These findings strongly indicate that boys and girls are vulnerable to this form of childhood maltreatment; the similarity in the likelihood for multiple behavioral, mental, and social outcomes among men and women suggests the need to identify and treat all adults affected by CSA.

Male rape, in the UK, is defined as;

1) A person (a) commits an offense if, when with another person (b)-

- **a) intentionally penetrates the anus or mouth, of another (b) male with his penis,**

- **b) there is no consent to the penetration and**

- **c) If (a) does not reasonably believe that (b) consented.**

(2) Whether a belief is reasonable is to be determined having regard to all the circumstances, including any steps (a) has taken to ascertain whether (b) consented

Rape is usually understood by average society to be the penetration of a woman by a violent and aggressive man, and literature indicates usually not known to the victim. Men cannot be raped, especially not by a woman and another man can only indecently assault a man. Statistics from RapeCrisis indicate that men are less likely to report rape and that one in seven men are raped. Donaldson (1990), as quoted by RapeCrisis, states that in ancient times, "there was a widespread belief that a male who was sexually penetrated, even if it was by forced sexual assault, thus 'lost his manhood,' and could no longer be a warrior. Gang rape of a male was considered an ultimate form of punishment and, as such, was known to the Romans as punishment for adultery and the Persians and Iranians as punishment for violation of the sanctity of the harem."

Recent Violence Among **Men** with Severe Mental Disorders

- In past year, 8% experienced **sexual** assault
- In past year, 34% experienced **physical** assault

Prevalence of *Physical* Abuse Among **Males**

- Community samples: >30%
- Clinically-identified samples higher
  - **58% in childhood**
  - **79% in adulthood**
  - **86% lifetime**

Prevalence of *Sexual* Abuse Among **Males**

- Community samples: 4-24%
- Clinically-identified samples:
  - **Men with severe mental disorders: ~30-35% in childhood and ~25% in adulthood**
  - **Male runaway youths: 38%**
  - **Almost 100% of male/boy prostitutes**

Identified Risk Factors for **Male** Sexual Abuse

- Under the age of 13
- Nonwhite
- Low socioeconomic status
- Not living with their fathers

Issues in **Male** Trauma Prevalence Estimates

- Definitional ambiguities and differences
- Under-reporting
  - Gender role barriers
  - Cognitive barriers
- Under-recognition
  - Unasked or unclear questions
  - Stereotypes minimizing prevalence
  - Stereotypes minimizing impact
  - Lack of service resources
- Inadequate follow-through

Initial Impact of Trauma on **Males**

- "Externalizing" behaviors
  - aggression, delinquency, truancy
  - substance abuse
  - sexualized behaviors
- Physical and somatic complaints
- Emotional reactions

Long-Term Impact of Trauma on **Males**

- Low self-esteem and depression
- Work and school difficulties
- Relationship difficulties
- Substance abuse disorders
- Sexual problems
- Aggression and interpersonal violence
- High-risk/high-stimulation behaviors

Difference in Impact of Trauma for **Men** and Women?

- Exposed to different types of trauma
- Exposed to different characteristics of trauma (even if trauma is same type)
- Different attributions about trauma
- Different coping styles
- Different trauma sequelae
- Different "cultures"

Gender and Trauma Exposure

- Community samples
  - Overall rates of exposure depend on definition
  - Women report more sexual assault and child abuse
  - **Men** report more physical assault, combat, life-threatening accidents
- Individuals with severe mental disorders
  - Women report more child sexual abuse and sexual assault in adulthood
  - **Men** report more attacks with a weapon and witnessing a killing or serious injury

Gender and Child Sexual Abuse Trauma Characteristics

- Women report more negative coercion (force and threats)
- **Men** report more positive coercion (rewards or promised rewards)
- Women more likely to report multiple victimizations
- Women more likely to report abuse by close family member

Gender and Trauma Attributions

- **Men** less likely to report extreme fear in response to similar traumas
- Women more likely to blame themselves
- Women more likely to hold negative views of themselves
- Women more likely to perceive the world as dangerous
- Women more likely to experience betrayal trauma

Gender and Coping Styles

- Women more emotionally expressive
- **Men** more action-oriented
- Women: “tend and befriend”
- **Men**: “fight or flight”

Gender and Trauma Sequelae

- **Boys** more “externalizing” and girls more “internalizing”
  - **Boys:** more aggression, truancy, substance use
  - Girls: more depression, anxiety
- Women more likely to develop PTSD

Gender and Culture

- Gender role expectations shape the ways in which trauma is experienced
- These expectations shape the ways in which trauma is interpreted
- These expectations shape the ways in which trauma recovery proceeds

Facts about Sexual Abuse of Boys and its Aftermath

Up to one out of six **men** report having had unwanted direct sexual contact with an older person by the age of 16. If we include non-contact sexual behavior, such as someone exposing him- or herself to a child, up to one in four **men** report **boyhood** sexual victimization.

On average, **boys** first experience sexual abuse at age 10. The age range at which **boys** are first abused, however, is from infancy to late adolescence.

Boys at greatest risk for sexual abuse are those living with neither or only one parent; those whose parents are separated, divorced, and/or remarried; those whose parents abuse alcohol or are involved in criminal behavior; and those who are disabled.

Facts about Sexual Abuse of Boys and its Aftermath

Boys are most commonly abused by **males** (between 50 and 75%). However, it is difficult to estimate the extent of abuse by females, since abuse by women is often covert. Also, when a woman initiates sex with a **boy** he is likely to consider it a "sexual initiation" and deny that it was abusive, even though he may suffer significant trauma from the experience.

A smaller proportion of sexually abused **boys** than sexually abused girls report sexual abuse to authorities.

Common symptoms for sexually abused **men** include: guilt, anxiety, depression, interpersonal isolation, shame, low self-esteem, self-destructive behavior, post-traumatic stress reactions, poor body imagery, sleep disturbance, nightmares, anorexia or bulimia, relational and/or sexual dysfunction, and compulsive behavior like alcoholism, drug addiction, gambling, overeating, overspending, and sexual obsession or compulsion.

Facts about Sexual Abuse of Boys and its Aftermath

The vast majority (over 80%) of sexually abused **boys** never become adult perpetrators, while a majority of perpetrators (up to 80%) were themselves abused.

There is no compelling evidence that sexual abuse fundamentally changes a **boy's** sexual orientation, but it may lead to confusion about sexual identity and is likely to affect how he relates in intimate situations.

Boys often feel physical sexual arousal during abuse even if they are repulsed by what is happening.

Perpetrators tend to be **males** who consider themselves heterosexual and are most likely to be known but unrelated to the victims.

For **males**, being raped by a person of the same sex has significant implications for how they:

- Perceive their rape
- Behave after the rape
- View their sexuality
- Are judged by others
- Recover from the assault

… there is no way to see **men** as “victims” and still as **men**.

Scarce, M: Male on Male Rape: The hidden Toll of Stigma and Shame – Insight Books, New York, 1997

Is trauma something men are allowed to experience or have traditional constructions of gender placed trauma only within the realm of the feminine? Thus, to what extent is a man who is traumatized seen as less of a "man", possibly as more of a "woman", or even worse, a "womanly man", a ”pansy”, or a ”sissy?”

Men get traumatized just like women and children do, despite constructions to the contrary. A (Ph.D.) (Eagle, 2000) study at the University of the Witwatersrand has shown that **men** process trauma in a much more complex manner than women do exactly because they have been denied the opportunities and skills required to process trauma.

Some of the essentialist constructs making a **man** a **man**, is that **he** can defend **him**self and that **he** is sexually virile, dominant and possibly aggressive. Other traditional constructs of the male role, or masculinity, may include an emphasis on competition, status, toughness, and emotional stoicism. Contemporary scholars of **men's** studies view certain **male** problems such as violence, devaluation of women, fear and hatred of homosexuals, detached fathering, and neglect of health needs as unfortunate, yet predictable results of the **male** role socialization process.

Daphne, J: A new masculine Identity: gender awareness raising for men – Agenda Vol. 37

Zoloft (sertraline hydrochloride), is approved for both **men** and women to treat several conditions, including post-traumatic stress disorder (PTSD). This approval was based on clinical trials in which Zoloft showed little effect in **men** with PTSD, while the drug's benefit over a placebo was clear in the women studied.

"True gender differences in responsiveness may be one explanation," says Thomas Laughren, M.D., team leader for the FDA's psychiatric drug products group. "However, it should also be noted that the types of PTSD differed in the two groups," he says. Many of the **men** in these trials had a long-lasting and treatment-resistant PTSD, based on military combat experience, compared to many of the women who tended to have a more acute form of PTSD, based on recent physical abuse.

Men are expected to handle our pain ‘stoically’ and alone. If **men** feel pain, we aren’t supposed to acknowledge it, and certainly not ask for help, for this would reinforce the feeling of a ‘lack of masculinity’ – a feeling based on the notion that ‘**men**’ aren’t supposed to be victims in the first place.

Ruiters, K and Shefer, T: The Masculine Construct in heterosex – Agenda Vol. 37

7 Myths About Male Sexual Victimization

Myth #1 - Boys and men can't be victims (“He could have prevented it.”)

This myth, instilled through masculine gender socialization and sometimes referred to as the "macho image," declares that males, even young boys, are not supposed to be victims or even vulnerable. We learn very early that males should be able to protect themselves. In truth, boys are children - weaker and more vulnerable than their perpetrators - who cannot really fight back. Why? The perpetrator has greater size, strength, and knowledge. This power is exercised from a position of authority, using resources such as money or other bribes, or outright threats - whatever advantage can be taken to use a child for sexual purposes.

The belief that a male victim could have prevented an assault ignores a basic reality: the threat of bodily harm or death can overpower the desire to defend oneself.

7 Myths About Male Sexual Victimization

Myth #2 - Most sexual abuse of boys is perpetrated by homosexual males.

Pedophiles who molest boys are not expressing a homosexual orientation any more than pedophiles who molest girls are practicing heterosexual behaviors. While many child molesters have gender and/or age preferences, of those who seek out boys, the vast majority are not homosexual. They are pedophiles.

7 Myths About Male Sexual Victimization

Myth #3 - If a boy experiences sexual arousal or orgasm from abuse, this means he was a willing participant or enjoyed it (“He asked for it.”)

In reality, males can respond physically to stimulation (get an erection) even in traumatic or painful sexual situations. Therapists who work with sexual offenders know that one way a perpetrator can maintain secrecy is to label the child's sexual response as an indication of his willingness to participate. "You liked it, you wanted it," they'll say. Many survivors feel guilt and shame because they experienced physical arousal while being abused. Physical (and visual or auditory) stimulation is likely to happen in a sexual situation. It does not mean that the child wanted the experience or understood what it meant at the time.

7 Myths About Male Sexual Victimization

Myth #4 - Boys are less traumatized by the abuse experience than girls.

While some studies have found males to be less negatively affected, more studies show that long term effects are quite damaging for either sex. Males may be more damaged by society's refusal or reluctance to accept their victimization, and by their resultant belief that they must "tough it out" in silence.

7 Myths About Male Sexual Victimization

Myth #5 - Boys abused by males are or will become homosexual.

While there are different theories about how the sexual orientation develops, experts in the human sexuality field do not believe that premature sexual experiences play a significant role in late adolescent or adult sexual orientation. It is unlikely that someone can make another person a homosexual or heterosexual. Sexual orientation is a complex issue and there is no single answer or theory that explains why someone identifies himself as homosexual, heterosexual or bi-sexual. Whether perpetrated by older males or females, boys' or girls' premature sexual experiences are damaging in many ways, including confusion about one's sexual identity and orientation.

Many boys who have been abused by males erroneously believe that something about them sexually attracts males, and that this may mean they are homosexual or effeminate. Again, not true. Pedophiles who are attracted to boys will admit that the lack of body hair and adult sexual features turns them on. The pedophile's inability to develop and maintain a healthy adult sexual relationship is the problem - not the physical features of a sexually immature boy.

7 Myths About Male Sexual Victimization

Myth #6 - The "Vampire Syndrome", that is, boys who are sexually abused, like the victims of Count Dracula, go on to "bite" or sexually abuse others.

This myth is especially dangerous because it can create a terrible stigma for the child, that he is destined to become an offender. Boys might be treated as potential perpetrators rather than victims who need help. While it is true that most perpetrators have histories of sexual abuse, it is NOT true that most victims go on to become perpetrators. Research by Jane Gilgun, Judith Becker and John Hunter found a primary difference between perpetrators who were sexually abused and sexually abused males who never perpetrated: non-perpetrators told about the abuse, and were believed and supported by significant people in their lives. Again, the majority of victims do not go on to become adolescent or adult perpetrators; and those who do perpetrate in adolescence usually don't perpetrate as adults if they get help when they are young.

7 Myths About Male Sexual Victimization

Myth #7 - If the perpetrator is female, the boy or adolescent should consider himself fortunate to have been initiated into heterosexual activity.

In reality, premature or coerced sex, whether by a mother, aunt, older sister, baby-sitter or other female in a position of power over a boy, causes confusion at best, and rage, depression or other problems in more negative circumstances. To be used as a sexual object by a more powerful person, male or female, is always abusive and often damaging.

Treatment Issues for Men

There are very few resources that are specifically designed for sexually abused men. Ones that do exist often fail to address homophobia and sexism, which have a direct impact on all men, including heterosexual men.

Services that do exist often fail to challenge stereotypical notions of the male gender role that perpetuate shame, feelings of inadequacy, and non-disclosure.

Treatment issues specific to men who have been sexually abused:

- Self-blame;
- Feelings of inadequacy and shame about their gender;
- Confusion, inner conflict, fear and shame about their sexuality;
- Mistaking male-to-male sexual abuse for gay sex;
- Fear that being abused by a man means that they might be gay, or that it caused them to be gay
- Feelings of inadequacy for continuing to be affected by the abuse;
- Minimization of the abuse and its effects;
- Problems with relationships and sex that stem from inner conflict about their gender and sexual identification.

Treatment of Abused Men (1)

While no two rape victims are alike, there are common elements in all rapes. You can help by:

- Believing him and listening to him
- Knowing what to expect and helping him to understand what is happening
- Accepting his feelings and recognizing his strengths
- Communicating compassion and acceptance
- Encouraging him to make decisions that help him to regain control
- Treating his fears and concerns as understandable responses
- Working to diminish his feelings of being isolated and alone
- Holding realistic expectations, especially when he becomes frustrated or impatient
- Helping him to identify resources and support persons
- Do not tell him that everything is all right when everything is *not* all right. Avoid minimizing the gravity of what has happened because this suggests that you cannot deal with the situation.
- Do not touch or hold him without asking permission or unless he shows signs that such comfort is welcome.
- Do not try to lift his spirits by making jokes about what has happened.
- Do not tell him you know how he feels. Only he truly knows.

Treatment of Abused Men (2)

- ***Respect his fear.*** Offenders commonly threaten to seriously harm the victims if their victims do not comply or if they tell anyone what happened. Although this fear remains long after the sexual assault, male victims especially are reluctant to admit that they are afraid. Tell him that fear is a normal and understandable reaction; being fearful does not make him a coward.
- ***Accept*** his strong feelings and his mood swings, and remain consistent in your support.
- ***Be patient.*** Listen without being critical and without giving unsolicited advice. Let him express his feelings at a pace that is comfortable to him. If he is reluctant to talk, do not become angry.
- ***Respect*** his wishes for confidentiality. He alone should decide with whom and under what circumstances to discuss his feelings. Remember, in the aftermath of rape, victims tend to be reluctant to discuss their feelings about the attack. Others, however, may interpret such reluctance to talk as unhealthy withdrawal. In a well-intended effort to be helpful, others might then solicit without the victim's permission assistance from co-workers, clergy, or mental health professionals. Such attempts to intervene, unless requested by the victim, should be discouraged.

Treatment of Abused Men (3)

* ***Empower*** him; do not try to control or overprotect him. Apart from security needs of young children, there should never be the equivalent of twenty-four hour surveillance of the rape victim. Such monitoring could unintentionally reinforce his feelings of vulnerability and powerlessness.

* ***Let him decide*** when a "distraction" is appropriate and necessary. The rape victim will not recover from an attack simply because others do things to "take his mind off of it." Engaging in a "friendly conspiracy" with others to keep the victim's mind off the rape by acting as if it never happened is counterproductive. The victim could mistake these diversions to mean that his family and friends regard the assault as too awful to discuss or too trivial to acknowledge. True, there are times when the victim might want to engage in distracting activities, but it should be at the victim's request.

* ***Remind family members*** and friends that the rape victim has privacy needs. When he expresses the desire to be alone, this desire should be respected. Sometimes a constant stream of well-wishers will be an emotional drain. In respecting the victim's wish for privacy, you will send two empowering messages: he is the best judge of what he needs, and he has the strength to help himself get better.

Treatment of Abused Men (4)

✱ ***Remind others*** that they should never imply that the attack was caused by what the victim did or did not do. Such second-guessing is a form of "victim-blaming" that reinforces guilt and self-blame.

✱ ***Encourage*** discussions about the nature and negative consequences of homophobia. Viewing same-sex rape through the distorted lens of homophobia only harms victims.

✱ ***Do not*** tell him that he "shouldn't think about the incident," or "shouldn't feel that way," or that he "should be over it by now." He cannot will himself to ignore troublesome images or to bury powerful feelings. Suggesting that he attempt to do so will undermine communication and will hinder his recovery.

✱ ***Do not*** become irritated because he has needs that place additional demands on you. He is reaching out to you, not because he wants to burden you unnecessarily, but because you are a person upon whom he can rely for understanding and support.

Treatment of Abused Men (5)

- ***Do not*** be upset if he refuses to accept help that you or others may offer. For many male victims of rape, accepting help seems to be an admission of weakness. Many males will absolutely refuse to go through counseling, even though this may be beneficial to them. Do not demand that the victim "get help" or constantly badger him about the counseling option. A better strategy is to provide him with helpful materials that he can read or view on his own. Most rape-crisis or counseling centers have such materials available.

- ***Do not*** become angry if his recovery seems too slow. Remember, rape victims recover at different rates and in different ways. Try not to impose your terms of recovery on him. Such an imposition communicates a lack of understanding rather than compassion, and is likely to cause resentment.

- ***Suggest that he and his partner consider*** doing some of the joint activities that brought them closer together in the past. For most rape victims, a sharp dividing line now exists between their pre- and post-assault memories. Engaging in joint activities gives both he and his partner opportunities to rediscover those positive experiences that constitute the pre-assault foundations of their relationship.

Treatment of Abused Men (6)

* ***Suggest that he seek*** the companionship of friends who are healthy and upbeat, when it is appropriate. The good cheer he can experience from being around positive people may provide a brief (and needed) respite.

* ***Control your feelings of anger and suggest that his partner not*** act in violent ways in the mistaken belief that violence is a good release for pent-up anger. Similarly, turning to alcohol does not eliminate feelings of anger. If anything, violence and alcohol consumption may harm the relationship and are destructive. Furthermore, he may recoil from anything or anyone associated with anger or violence.

* ***Suggest*** that he find a support group with whom he can talk without fear of being judged. Support groups where members discuss their experiences and strategies for healing are often available through rape-crisis centers. Knowing that others have endured what he is going through can provide hope.

Treatment of Abused Men (7)

You can help if you reassure him that:

- You believe he is not permanently impaired
- You are optimistic about his ability to put his life back in order
- He can heal his wounds, even if the rape is never forgotten
- He has the strength to resist the stigma associated with being a rape victim
- He can achieve recovery by turning his anger into the motivation for regaining control over his life and moving forward, despite what has been done to him

Treatment of Abused Men (8)

* **The different forms of abuse:** Many men focus on the sexual aspect of the abuse and not the totality. They may overlook: coercion, the nature of the relationship with the perpetrator, power differences, emotional abuse, and any other abuse they experienced as a child. Broadening their understanding of abuse helps to reduce their self-blame.

* **Effects of the abuse and coping strategies:** Many men have not looked at the whole picture of how the abuse has affected and continues to affect their lives. They may have viewed their coping strategies as "weaknesses" rather than self-protection. Focusing on this theme helps to reduce their tendency to minimize and to feel badly about themselves.

* **The larger context:** It is important to examine the messages they received at home, and from their community, about themselves and what it means to be male. It can help to explore how these messages left them vulnerable to: being abused, feeling ashamed, and staying silent. This work can be very empowering for men and helps them to feel angry about not being protected.

Treatment of Abused Men (9)

* **Permission to feel:** Many men have never let themselves cry, feel sad, or grieve the abuse, particularly in the company of other men. Encouraging and supporting men to express their feelings and to be vulnerable with one another is important work.

* **Permission to have needs:** As children, many men's emotional needs were rebuffed, particularly by their fathers. Sexual abuse reinforces this: it tells them that their needs are not important, and that men are not supportive; they reject and abuse. Men need to have opportunities to give to and receive support from other men, in order to break these patterns and to affirm their male identity.

* **Sexuality:** It is important to encourage men to explore their beliefs about and problems with their sexuality, particularly as it relates to sexual abuse. An openness about gay, bi and straight sexuality is essential and encourages a thorough exploration of their true feelings. Ambivalence and confusion may be an important part of the process for both gay and straight men.

Stages in Trauma Recovery

- **Early recognition**: obstacles for survivors and for clinicians in addressing trauma
- **Recognition**: engagement becomes highest priority
- **Active trauma recovery**: group or individual work focused on trauma and recovery
- **Future orientation**: continuing the healing process and consolidating recovery skills

Recognition: Engaging Male Trauma Survivors in Services

- Addressing obstacles to men's involvement in trauma-specific services
- Addressing strengths men bring to trauma-specific services

Obstacles to Engagement

- The "Disconnection Dilemma"
- Lack of familiarity and/or comfort with emotional language
- Lack of comfort with relationship-centered discussions
- Extreme responses to potential stressors: all-or-nothing intensity

Strengths for Engagement

- Pride and self-esteem related to survival and coping: "Look what I've been through."
- Analytical tendencies: "I can figure this out."
- Bias in favor of problem-solving: "It's what men do."

Active Trauma Recovery

- Understanding relationships between gender role expectations and trauma
- Understanding emotions and relationships
- Understanding trauma and its often broad-based impact
- Understanding recovery skills and their use

Gender Role Expectations and Trauma

- The “Male Myths”
- Being a man is not the problem
- Rigid male stereotypes are a problem
- Emotional constriction is a problem
- Drawing on strengths is part of the solution

Emotions and Relationships

- What do men need in order to address trauma more directly?
- Key emotional realities: anger, fear, sadness, shame, hope
- Key relational realities: trust, loss, sexuality and intimacy

Trauma and Its Impact

- Understanding trauma in general
- Understanding specifics of emotional, physical, and sexual abuse
- Understanding the impact of trauma on psychological “symptoms,” on addictive or compulsive behavior, and on relationships

Recovery Skills

- Self-Awareness
- Self-Protection
- Self-Soothing
- Emotional Modulation
- Relational Mutuality
- Accurate Labeling of Self and Others
- Sense of Agency and Initiative-Taking
- Consistent Problem-Solving
- Reliable Parenting
- Possessing a Sense of Purpose and Meaning
- Judgment and Decision-Making

Future Orientation

- Consolidating skills in new activities and relationships
- Setting realistic goals
- Planning steps to meet vocational, educational, and residential needs
- Realistic appraisal of future relationships
- Assessment of future services and sources of help

Steps in Recovery at Each Stage

- Recognize
- Understand
- Choose
- Practice
- Evaluate

Summary

- Male trauma exposure is widespread
- Men bring unique strengths and vulnerabilities to each stage of trauma recovery
- Clinicians need to be flexibly attuned to gender roles in relation to trauma and recovery

Healing or recovery from trauma

Survivors of trauma need to be in charge of their own recovery

Empowerment–You must be in charge of your healing in every way to counteract the effects of the trauma where all control was taken away from you.
Validation–You need others to listen to you, to validate the importance of what happened to you, to bear witness, and to understand the role of this trauma in your life.
Connection–Trauma makes you feel very alone. As part of your healing, you need to reconnect with others. This connection may be part of your treatment.
If you feel the cause of your symptoms is related to trauma in your life, you will want to be careful about your treatment and in making decisions about other areas of your life. The following guidelines will help you decide how to help yourself feel better.
Have hope. It is important that you know that you can and will feel better. In the past you may have thought you would never feel better—that the horrible symptoms you experience would go on for the rest of your life. Many people who have experienced the same symptoms that you are experiencing are now feeling much better.
They have gone on to make their lives the way they want them to be and to do the things they want to do.
Take personal responsibility. When you have been traumatized, you lose control of your life. You may feel as though you still don't have any control over your life. You begin to take back that control by being in charge of every aspect of your life. Others, including your spouse, family members, friends, and health care professionals will try to tell you what to do. Before you do what they suggest, think about it carefully. Do you feel that it is the best thing for you to do right now? If not, do not do it. You can follow others advice, but be aware that you are choosing to do so. It is important that you make decisions about your own life. You are

responsible for your own behavior. Being traumatized is not an acceptable excuse for behavior that hurts you or hurts others.

Talk to one or more people about what happened to you. Telling others about the trauma is an important part of healing the effects of trauma. Make sure the person or people you decide to tell are safe people, people who would not hurt you, and who understand that what happened to you is serious. They should know, or you could tell them, that describing what happened to you over and over is an important part of the healing process. Don't tell a person who responds with statements that invalidate your experience, like "That wasn't so bad." "You should just forget about it," "Forgive and forget," or "You think that's bad, let me tell you what happened to me." They don't understand. In connecting with others, avoid spending all your time talking about your traumatic experiences. Spend time listening to others and sharing positive life experiences, like going to movies or watching a ball game together. You will know when you have described your trauma enough, because you won't feel like doing it anymore.

Develop a close relationship with another person. You may not feel close to or trust anyone. This may be a result of your traumatic experiences. Part of healing means trusting people again. Think about the person in your life that you like best. Invite them to do something fun with you. If that feels good, make a plan to do something else together at another time—maybe the following week. Keep doing this until you feel close to this person. Then, without giving up on that person, start developing a close relationship with another person. Keep doing this until you have close relationships with at least five people. Support groups and peer support centers are good places to meet people.

Principles of Care
How to connect when the person seems elsewhere

1. **Always know that there is a person inside**

2. **Relate as if the person inside wants you to understand them**

3. **There is always hope of recovery and it is vital to communicate that from the start in all mannerisms**

4. **Realize that the person in distress is acutely aware of every emotional nuance you are experiencing, so be honest and authentic**

5. **Your way of being with the person is most important; being there in the moment is most appreciated**

6. **Listen with all your heart first and foremost**

7. **Be humble, curious, respectful, leaving your theories at the door**

8. **Be there deeply with the other person, sharing your full self (be meditative)**

9. **Minimize any distractions, especially of a mechanical nature**

10. **Try to understand the person's meaning, realizing that distress appears crazy due to a lack of understanding by you and them of what the person in distress is trying to tell you and themselves about why they are upset**

11. **"When a person with schizophrenia is understood they are no longer schizophrenic" (C. Jung)**

12. **Always look for ways to increase the person's control and collaboration**

Principles of Recovery from Trauma, Disasters and Severe Mental Disorders

Trauma	Disaster (Psychological First Aid)	Severe mental disorders
Empowerment	Safety through increased control	Empowerment
Connection with others	Contact and Engagement	Connection
Trust	Non-verbal connecting first	Trust
Autonomy	Information on coping with stress	Self-determination
Positive identity	Active agent rather than victim	Survivor, person
Respect & mutuality	Respectful & compassionate	Dignity & Respect

Psychological First Aid

(from National Center on PTSD)

Basics of Psychological First Aid

1. Expect normal recovery
2. Assume survivors are competent
3. Recognize survivor strengths
4. Promote resilience

Psychological First Aid Core Actions

1. Contact and engagement: respectful and compassionate
2. Safety and comfort: through active involvement
3. Stabilization (if needed): calm and sooth emotionally
4. Information gathering: immediate needs and concerns addressed
5. Practical assistance: problem solving
6. Connecting with social supports
7. Information on stress and coping
8. Linkage with collaborative services

1. Contact and Engagement

Goal: To respond to contacts initiated by affected persons, or initiate contacts in a non-intrusive, compassionate, and helpful manner.

The first contact with a survivor is important. If managed in a respectful and compassionate way, it can help establish an effective helping relationship and increase the person's receptiveness to further help

- Introduce self and describe role
- Ask for permission to talk
- Explain objective
- Ask about immediate needs
- Be informed about cultural norms related to personal contact

2. Safety and Comfort

Goal: Enhance immediate and ongoing safety, and provide physical and emotional comfort.

Doing things that are active (rather than passive waiting), practical (using available resources), and familiar (drawing on well-learned behaviors that do not require new learning) can increase a sense of control over the situation.

Enhance sense of predictability, control, comfort, and safety through information about the situation, what to do next, normal reactions to abnormal situations.

- Ensure immediate physical safety
- Provide information about disaster response activities/services
- Offer physical comforts
- Offer social comforts
- Attend to children who are separated from their parents/caregivers
- Protect from additional trauma and potential trauma reminders
- Help survivors who have a missing family member
- Help survivors when a family member or close friend has died
- Attend to grief and spiritual issues
- Provide information about casket and funeral issues
- Attend to issues related to traumatic grief
- Support survivors who receive death notification
- Support survivors involved In body identification
- Help caregivers confirm body identification to a child or adolescent

3. Stabilization (if needed)

Goal: To calm and orient emotionally-overwhelmed or disoriented survivors

a. enlist aid of family or friends in comforting or providing emotional support to the distressed person
b. offer a drink, chair, or small talk rather than trying to engage in lengthy conversation as this may contribute to emotional overload
c. help him or her focus on specific manageable feelings, thoughts, and goals.

- Stabilize emotionally overwhelmed survivors
- Develop and focus on talking points for emotionally overwhelmed survivors
- Discuss the role of medications in stabilization

Signs a Survivor is Disoriented or Overwhelmed

- Looking glassy eyed and vacant
- Unresponsive to verbal questions or commands
- Disoriented
- Exhibiting strong emotional and physical responses (uncontrollable crying, hyperventilating, rocking or regressive behavior, shaking, trembling)
- Exhibiting frantic searching behavior
- Feeling incapacitated by worry
- Engaging in risky activities

If extremely agitated or losing touch with the surroundings:

- Ask them to listen to and look at you
- Speak softly and calmly
- Orient to surroundings
- Talk about aspect of the situation that is under their control, hopeful, or positive

4. Information Gathering and Planning

Goal: To identify immediate needs and concerns, gather additional information (as appropriate to the situation), and tailor Psychological First Aid it is especially important to follow the lead of the survivor in discussing what happened during the event (similar to person driven planning).

Current Needs and Concerns

- Form and maintain an alliance with the survivor
- Remain sensitive to survivor needs and perceptions
- Identify individuals in need of immediate referral
- Identify components of PFA that may be especially helpful
- Integrate survivor education with informal assessment
- Identify need for additional services or referral

Content Areas

- Nature and severity of experiences
- Death of a loved one
- Concerns about the immediate post-disaster circumstances and ongoing threat
- Separation from or concerns about the safety of loved ones
- Physical illness and need for medications
- Losses incurred as a result of the disaster
- Feelings of guilt or shame
- Thoughts about causing harm to self or others
- Developmental Impact
- Lack of adequate supportive social network
- Prior alcohol or drug use or psychiatric problems
- Prior exposure to trauma and loss

5. Practical Assistance

Goal: To offer practical help to the survivor in addressing immediate needs and concerns. Survivors may welcome a pragmatic focus on a current problem that is uppermost in their mind. Often, it is important to help them with problem-solving in regard to important problems

- Identify the most immediate need(s)
- Clarify the need
- Discuss an action response
- Act to address the need

6. Connection with Social Supports

Goal: To help establish, as quickly as possible, brief or ongoing contacts with primary support persons or other sources of support, including family members, friends, peers, and community helping resources.

- Enhance access to primary support persons (family and significant others)
- Encourage use of immediately-available support persons
- Discuss support-seeking
- Special considerations for children and adolescents
- Model supportive behavior

7. Information on Coping

Goal: To provide information (about stress reactions and coping) to reduce distress and promote adaptive functioning such as visualization, progressive relaxation, meditation, positive affirmations, etc.

- Provide basic information about common psychological reactions to traumatic experiences and losses
- Talk with children and body and emotional reactions
- Provide basic information on ways of coping
- Teach simple relaxation techniques
- Assist with developmental issues
- Assist with anger management Address highly negative emotions
- Address highly negative emotions (e.g., guilt, shame)
- Help with sleep problems
- Address alcohol and substance use

8. Linkage with Collaborative Services

Goal: To link survivors with needed services, and inform them about available services that may be needed in the future.

- Provide direct links to additional needed services
- Promote continuity in helping relationships

Emotional First Aid

Do's and Don'ts

- Get together with family and friends and support each other.
- Organize and meet in community groups in neighborhoods, YMCAs and religious centers.
- Don't be isolated.
- Try to get the information about your loved ones ASAP, watch the news for limited times and then turn it off for a while. You can put the TV on every two hours to get the information you need, but do not get hooked on its traumatic images.
- It is crucial to refocus on your resources, anything that helps you feel calmer, stronger and more grounded refocus on all your support systems. Do things that keep your mind occupied, such as watching a movie, knitting, gardening, cooking, playing with children or pets or going in nature.
- Stay active and volunteer help in the hospitals or give blood. You can send money or help staff help lines for distressed people.
- Encourage people and yourself not to tell their stories in a repetitive way which ultimately deepens the trauma, and instead support and hear each other about this real tragedy/catastrophe, but with interruptions of the story from beginning to end. Feel your feelings and allow your emotions to be expressed in a rational framework and in productive actions that you may chose to take. This will help you to process feelings without overwhelming yourself and not get stuck in obsessive thinking.

Psychological Response

People can have many different reactions to the tragedy.

- Some will be in shock, stunned and dissociated for a while. They may feel numb and cut off from the terror and pain.
- Children may become 'clingy' and have nightmares. Alternatively, they may act out aggressively. This is normal. It might last a few days or more but it will pass. They need to be reassured and feel protected.
- People may feel fear and deep sorrow, confusion, anger and helplessness. These feelings are normal too and will pass.
- People may feel anxious, hyper-vigilant ('on guard') and easily irritated. They need to engage in activities and creative expression that calms them. Being with family members and friends can help calming.

Physiological Response

It is natural to have a physical reaction to this stress, so don't let these scare you. It is good to recognize signs of 'activation' and not to be scared by them:

- heart beating faster
- difficulty breathing
- blood pressure going up
- stomach tightening, knot in the throat
- skin cold and racy thoughts
- these reactions will dissipate-go away-if we don't fight them
- people might experience some difficulty sleeping, wanting to eat too much, salty or sweet food, and might want to engage in addictive behaviors such as excessive use of alcohol or drugs
- Symptoms can be very diverse. They can be stable, or come and go. They can occur in clusters.
- Some people's old unresolved traumas may get re-triggered. Their sense of safety and trust may get shaken. They need to remind themselves of their names, their actual age and today's date and place.

The best 'antidote' is to try to be aware of these and other impulses, and to be accepting that you are deeply upset-and that it will pass.

Helpful Response

We can help our nervous system recuperate its balance by understanding how it discharges when it is over-stimulated. Some examples of this are:

- trembling, shaking or sweating
- warmth in our body
- stomach gurgling
- breathing deeply
- crying or laughing

These are good, it means that we are discharging some of this energy and coming back into balance. Mostly, we want to just observe what's happening in our body without judgment, just watching and understanding that our body has the innate ability to regain its balance if we just let it feel what it feels, and give it the time to do what it wants to do.

What to Do

It is very important to stay 'grounded.' If you are feeling disoriented, confused, upset and in disbelief, you can do the following exercise:

- Sit on a chair, feel your feet on the ground, press on your thighs, feel your behind on the seat, and your back supported by the chair; look around you and pick six objects that have red or blue. This should allow you to feel in the present, more grounded and in your body. Notice how your breath gets deeper and calmer. You may want to go outdoors and find a peaceful place to sit on the grass. As you do, feel how your bottom can be held and supported by the ground.
- Here is an exercise that will allow you to feel your body as a 'container' to hold your feelings. Gently pat the different parts of your body with your hand, with a loose wrist. Your body may feel more tingling, more alive, sharp, you may feel more connected to your feelings.
- Another exercise is to tense your muscles, each group at a time. Hold your shoulders with arms across your chest, tighten your grip on them and pat your arms up and down. Do the same with your legs, tighten them and hold them from the outside, patting through their length. Tighten your back, tighten your front, then gently release the tension. This may help you or your loved one feel more balanced.
- Sports, aerobics and weight training help avoid depression and are a channel for aggression.
- If you believe in prayer or in some sort of greater power, pray for the rest of the souls of the dead, for the healing of the wounded, for consolation for the grieving. Pray for peace, for understanding and wisdom and for the forces of goodness to prevail. Do not give up faith in the ultimate goodness of being and keep your trust in humanity.
- And last, just know that we, humans, are extremely resilient and have been able to recuperate from the most horrendous tragedies. Furthermore we have the ability to let ourselves be transformed by our traumas, when we heal them and open ourselves to the possibility.

Why have a policy on trauma?

- Because it is a major health issue, an underlying core issue that links many different human service agencies. It crosses socio-economic lines, gender, race, culture and all ages and has a negative influence that can last for generations. It affects a person's capacity to live an independent, healthy and safe life. If affects a person's capacity to benefit from many programs and services currently offered.

- Because it has largely been ignored, denied, dismissed for many years and has only, during the last 10 years or so, been backed up by research that demonstrates the long-term neurobiological impairment that can occur.

- Because we are now much more informed about the prevalence, incidence, devastating effects, the adult retraumatization, the existence of interpersonal violence and abuse, the acknowledgement of institutional abuse.

- Because trauma is often misdiagnosed or described as a secondary non-treated diagnosis.

- Because it is rarely consistently screened for in a sensitive, useful way.

- Because even when screened for there is often no assessment of the impact that the long-term effects of trauma may have on the person's response to services.

- Because even when there is an assessment there are often instances of unintended retraumatization of that person.

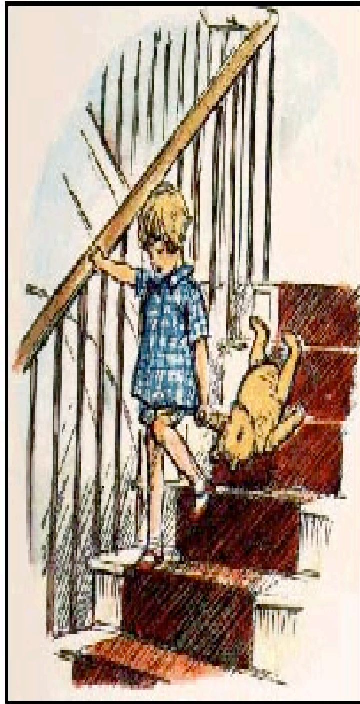
- Because most mental health and/or addictions disorders services do not operate within a trauma informed model.

- Because rarely is the consumer accepted as a full partner in his/her treatment, planning and evaluation and as an expert on his/her own needs.

Resources

Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Mental Health Services
Web site: www.samhsa.gov
SAMHSA's National Mental Health Information Center
P.O. Box 42490
Washington, D.C. 20015
1 (800) 789-2647 (voice)
Web site: www.mentalhealth.org

National Technical Assistance Center (NATC)
National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
703-739-9333 (voice)
703-548-9517 (fax)
Web site: www.nasmhpd.org/ntac



"Here's Edward Bear coming down stairs now, thump, thump, thump, on the back of his head behind Christopher Robin. It is, as far as he knows, the only way of coming down stairs but, sometimes he feels that there really is another way; if only he could stop thumping for a moment and think of it."

From "Winnie the Pooh" by A. A. Milne