

STRESS RESPONSES IN SEXUAL TRAUMA VICTIMS AND IN OTHERS EXPERIENCING OVERWHELMING EVENTS

*Helpful Strategies for Self, Children, Supporters, and What
Trauma Therapists Really Do*

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INCIDENTS OF SEXUAL ABUSE

Though the frequency of child and adult sexual victimization is estimated to be high, when it comes to understanding, assessing, and intervening with these survivors it is important to recognize that each person suffers a unique style and pattern of stress response—in general distress, loss of psychological and physical well-being, and lost of efficiency, self-esteem, and sense of competence in relating to self and world.

Generally, rates of childhood sexual abuse (CSA) for females range from 6 to 62% with an estimate of 25% occurring during the childhood years. The National Crime Victimization Survey (NCVS) estimated that 500,000 persons were sexually assaulted in the United States during the period between 1992 and 1993. Of this figure, 28% were attempted rapes, while over 33% were completed sexually traumatizing assaults.¹ More recent statistics indicate that in 2001 there were 249,000 victims of rape, attempted rape, or assault. Reporting incestuous experience with father before the age of 18 are 4.5% of women, while 4.9% were abused by their uncles.²

Sixty-six percent of prostitutes were abused by their father or father figures.³ While one in every six American women have been victims of attempted or completed rapes in their lifetime, on American college campuses one in every five women reported being a rape victim at some time during their lives.⁴ One in 5 children will be abused by age 18, and 85% of these will be abused by adults they know.

According to the National Center for Victims of Crime and Crime Victims Research and treatment Center, an estimated 683,000 women suffer sexual assault (SA) each year, and nearly one third of victims (approximately 211,000) suffer post-traumatic stress disorder (PTSD) at some time in their lives as a result of the crime.

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Studies reveal that CSA rates for males are 3 to 24% with an estimate of 1 in 10 up to 1 in 6 abused as children. Society adds a particular burden on male rape victims by viewing them as weak and labeling them as cowards and homosexuals. Compared to girls, boys are more likely to be abused by non-family members, such as coaches, priests or ministers, and instructors. Quite characteristic of male sexually abused victims are the emergence of two common stress response solutions, subconsciously organized to manage anxiety and low self-esteem: the *substance abuse solution* and the *violence/abuse perpetrator solution*. While the former “solution” represents a self-medicating practice to regulate alterations in brain functions that accompany abuse, the latter often results in the manufacture of new abuse victims. Though less frequent than in males, female victims may also show a tendency to violence and sexual escapades as negative coping patterns.

The pervasive post-abuse psychological symptoms that occur in boys may never come to the attention of parents, teachers, or therapists. They are more likely to suffer silently in the aftermath of the abuse, but muted emotional turmoil may take the form of deadly interpersonal violence and victimization of other people. This violence tendency is a psychological defense against abuse-related feelings of humiliation, degradation, anxiety, shame, low self-esteem, and a vanquished sense of masculine identity.

INCIDENTS OF NON-SEXUAL PSYCHOLOGICAL TRAUMA

At some point in their lives, an estimated 7.8 percent of Americans will experience PTSD. Women are twice as likely as men to develop the disorder. About 3.6 percent of U.S. adults aged 18 to 54 have PTSD during the course of a given year. Reporting at least one traumatic event were 60.7% of men and 51.2% of women.⁵

In terms of gender differential in traumatic suffering, PTSD for men is chiefly associated with rape, combat exposure, childhood neglect, and childhood physical abuse, while for women PTSD is associated with rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.⁶

Over half of all male Vietnam veterans and almost half of all female veterans have experienced serious symptoms of war stress. The lifetime prevalence of PTSD has been estimated among American Vietnam theater veterans is 30.9 for men and 26.9 for women. Additionally, 15.2 percent of all male Vietnam theater veterans and 8.1 percent of all female Vietnam theater veterans were “current cases” of PTSD back in 1988.⁷

More than half of all male Vietnam veterans and almost half of all female Vietnam veterans have experienced serious stress symptoms. Some estimates of PTSD among Gulf War veterans is as high as 8 percent.

PSYCHOLOGICAL IMPACT OF CHILDHOOD SEXUAL ABUSE, ADULT SEXUAL ASSAULT, AND OTHER TRAUMAS

Studies and clinical experience reveal that CSA victims are more likely to suffer severe mental illness, along with impulsive behavior, violence, suspiciousness, hostility,⁸ depression, anxiety, PTSD, borderline personality disorder, and self-destructive behavior. Women with sexual abuse histories were more likely than non-abused women to experience their sexual encounters with much less friendliness and more negative affect (i.e., hostility). These women were found to have almost three times as many sexual partners, as well as engaging in high-risk sexual practices when compared with women without a child sexual abuse history.⁹

Depending on the age of the person at the time of the trauma, adult patterns of sexual trauma symptoms differ significantly (e.g., trauma in early childhood vs. at the adolescent years, etc.).¹⁰ Child sexual abuse and assault victims of both genders often respond with numbing of emotions, and avoidance of feelings, people, places, and circumstances that may trigger horrific remembrance. They experience, moreover, memory problems, and high levels of anxiety. Also, many reexperience aspects of the abuse in waking and sleeping states, and go through the sense of being dazed or “spaced out,” feeling as if perceptions of self and world are dreamlike or illusory.

Trauma prevalence studies have consistently found high rates of PTSD among survivors of rape and physical assault. In a desperate attempt to cope with the onslaught of intrusive thoughts, depression, sense of helplessness, and high levels of hyperarousal, rape victims were found to be 13.4 times more likely to have a serious alcohol problem, and are 26 times more likely to have a serious drug abuse problem.¹¹

MULTIPLICITY OF STRESS RESPONSES AND LIFELINE EFFECTS AND ALTERATIONS

There are three types of psychological responses associated with sexual abuse or assault—normal, pathological, and growth-enhancing. Normal responses occur after overwhelming events, and often recede into the background in a very short period of time. However, some responses may persist, making it more difficult for the survivor to conduct his or her day-to-day routines. In this case, the unresolved stress responses adversely affect the person’s mind and body. These problematic reactions often result in behavioral and attitudinal patterns that interfere with survivors’ ability to use the blueprint (or innate potentialities) of their pre-trauma lives.

These normal responses become pathological when they persist for several weeks or months after the event and, instead of working through to completion or integration remain a pernicious psychological and biological influence on mind and body. The traumatic experience tend to distort each stage of the lifeline—childhood, adolescence, adulthood, middleage, and senescence (or the senior years). Some responses and

symptoms of this almost radical personality alteration are seen in the following response tendencies in victims:

- (1) Shame.
- (2) Traumatic sexualization (disturbance in sexual desire and functioning—either hypersex or sex avoidant).
- (3) Eating disorders.
- (4) Self-harming behavior.
- (5) Avoidance as a way of life—of thoughts, feelings, place, conversations, and taking action.
- (6) Flashbacks to the sexual trauma event.
- (7) Pervasive sense of vulnerability.
- (8) Sense of inner fragmentation and dissociation.
- (9) Sense of betrayal.
- (10) “Holding in” anger.
- (11) Pervasive sense of helplessness.
- (12) Low ambition.
- (13) Disturbance of memory—too much (hypermnesia), too little or non-existent (amnesia).
- (14) Concentration and attending difficulties.
- (15) Futurelessness.
- (16) Powerlessness.
- (17) Disturbed ideals.
- (18) Sense of hopelessness.
- (19) Pervasive relational disturbance.
- (20) Self-stigmatization.
- (21) “Sitting duck” behavior that leads to revictimization.
- (22) Pervasive sense of personal defilement.
- (23) Amnesia.
- (24) Distrust as a way of life—in relating to self (not trusting one’s own body, thoughts, feelings, and actions).
- (25) Self-blaming.
- (26) Self-despising.
- (27) Low self-esteem.

Complex PTSD and DID: Effects of Extreme, Prolonged Trauma

Early childhood trauma shatters the victim’s identity system, resulting in three major outcomes characterized by disorders of extreme stress (“Complex PTSD” also known as “Disorders of Extreme Stress” [DES]),¹² dissociative identity disorder (DID), and post-traumatic stress disorder (PTSD).¹³ DES occurs when the victim is exposed to “extreme, repetitive trauma”¹⁴⁻¹⁵ The stress responses associated with DES include a highly negative view of self as damaged with weak regulatory controls over the tendency to emotional reactivity in relation to anger, guilt, shame, and other emotions. Additionally, survivors experience self-destructive tendencies, as in suicidal thoughts, and self-mutilative behaviors (e.g., self abuse seen in wrist-cutting), seen chiefly in

sexual trauma survivors, and in adrenergic “living-on-the-edge,” self-destructive, risk-taking behavior in war veterans.

Survivors of sexual trauma also suffer distressing physical symptoms and medical conditions, poor social functioning, experiencing the “spaced out” feeling of being “unreal.” These difficulties often chip away at rational decision-making and general sense of well-being. Further complicating the chances of making positive forward movement in life, is the survivor’s problematic meaning system (e.g., absence of hope, lack of capacity for forgiveness, crushed religious faith, and distorted beliefs about self and others).

Severe early childhood abuse often results in the fragmenting of the identity system into DID, in which there is an absence of inner coherence among “the working parts of the self” (thinking, feeling, action, and the body’s sensory system). In this disorder, the survivor experiences various “personalities,” isolated into distinct, compartmentalized identities that fail to share information with each other. In the past this disorder was known as “multiple personality disorder.”

PTSD: How Its Symptoms Undermine the Sense of Competence in Transactions with Self and Others

Among the most common of medical disorders, post-traumatic stress disorder (PTSD). Survivor may also suffer post-traumatic stress disorder (PTSD), characterized by a stressor event, and a clustering of three types of symptoms—intrusion (fixation in vivid imagery on the trauma in body, thinking, feeling, feeling, behavior), avoidance (immobilizing coldness and absence of feeling), and arousal (involving irritability, inability to sleep, jitteriness, anger, etc.).

Intrusive Ideation: Too Much “Seeing” and Feeling

Intrusive ideation represents the most significant types of symptoms of traumatic stress in that it shapes the lifeline in terms of systematic organizing of one’s life to avoid potentially trigger external and internal events. Intrusive symptoms consist of vivid twilight recurring “flashes” representing fragments of traumatic memory—back to the event that make the survivor feel as if the trauma is happening *in the present*. Each sensory modality may serve as a triggering pathway to a network of terrifying memories and chilling emotional reactions within the victim. Thus, sounds, tastes, odors, and bodily sensations may activate reliving of latent trauma memories into active emotional reexperiencing of the trauma with attendant fear, helplessness, and horror of the past, experienced in the immediate present.

When the survivor’s internal world is experienced as a persistent danger zone, there is little or no internal peace or sense of security. These experiences of vivid, intrusive images and painful emotions often interfere with the ability to plan and make decisions, as they displace whatever the survivor may be thinking or doing in the moment. Trauma, therefore, takes the person away from the present moment, robbing

victims of the *now*. These symptoms take “center stage” in one’s life, especially when a flashback occurs. A flashback is a *reliving* symptom, a strong recollection forcing the individual to experience the horrific effects of the trauma as though it were recurring before your very eyes. Not getting a good night’s rest due to nightmares may plague the victim’s life from time to time, resulting in chronic tiredness and fatigue, listlessness, and feeling out of kilter in the morning that can continue for a part or entire day.

Avoidance and Diminished Engagement: Too Little “Seeing” and Feeling

While intrusive ideation leads to a lifestyle of hiding from life itself through persistent disengagement from self and world, the development of avoidance and numbing over time lead to human developmental arrests due to diminished awareness. This occurs when the survivor misses out in being exposed to the available diversity of stimuli from people, environmental features, situations, and certain events.

PTSD sufferers experience a reduction in awareness and avoid feelings, shutting down the self so the warmth or fire of emotions is replaced by cold numbness and emotional distancing. When this symptom goes on for a long time it can undermine the person’s capacity to express emotions, give and receive love, communicate with others on the emotional level, and even being able to experience truly safe relationships as safe, fulfilling, and trustworthy. Numbing and avoidance are observed in the use of alcohol, drugs, hyper-work, hyper-sex, and other exaggerated behavioral patterns.

Hyperarousal and Hypervigilance: The Body’s Counter-Terrorism System to Ward Off Intimations of Future Threats

When what happened to the survivor cannot be integrated into his or her experiential system. The individual may also feel unable to relax due to irritability and constantly feeling as though she or he is under threat of the return of dissociated terror of the original trauma. The body is constantly on alert to prevent any further “trauma/terrorism” from occurring again. Arousal involves becoming suddenly irritable, distrustful of the environment and people, and finding it difficult to focus and concentrate on things or attend to matters of importance. The constant feeling of danger as a consequence of PTSD puts distance between survivor and loved one, between friends, fellow employees, and between one’s church and community.

Unable to modulate anger and anxiety, the victim, in order to cope with trauma-based anxiety, may choose to drink alcohol excessively, use street drugs, or abuse prescription drugs. Many survivors find these practices are maladaptive and compound their problems as time goes on. Panic attacks are also reported among survivors of sexual traumatization.

SELF-HELP STRATEGIES FOR TRAUMATIZED ADULTS AND THEIR CHILDREN

In order to ensure you do all you can to facilitate the healing process after sexual victimization, here are a few actions you can take to help yourself, children, and family restore individual and collective psychological well being and sense of coherence.

What Can I *Expect* After Trauma?

- (1) You can expect the “quick-fix” impulse that will completely, overnight, eliminate your current suffering. But remember you will need time and lots of patience for post-trauma healing and recovery to occur.
- (2) You can expect to learn first before you gaining control.
- (3) Being realistic, you recognize what you have been through was a very difficult experience for yourself, and that the assault will challenge and test every capability you have.
- (4) Expect sleep problems.
- (5) You can expect to find your self becoming very irritable and angry over the slightest provocation and to feel depressed, sad, and alone.
- (6) Go easy on yourself, again, exercise patience; you are going through an extraordinarily difficult time, but you can *choose* to get out of it.
- (7) Expect ordinary life events to become more distressing than they were before the trauma.
- (8) You may expect to find your hear rate increase and pounding, feeling spacey, with perspiration, sometimes tremulousness, and increase in anxiety and fear.
- (9) Allow yourself to mourn the loss that occurs when sexual assault robs you of your sense of self—your motivation to go forward, ambition, ideals, identity, internal security, dignity, and aspirations for the future.
- (10) Keep in mind that even the most ordinarily loving and well-intentioned person may find it difficult hearing your story, and maintaining the level of empathy you need. But don’t give up; don’t get discouraged. Be patient with your self, be patient with and even understanding of others’ limitations to comprehend the enormity of your trauma-based suffering. understand, and be willing to

What Can I *Do* and What Should I *Resist* Doing After My Traumatic Ordeal?

- (11) Do reach out to family and friends with whom you can talk, and who will offer you their attention, and empathic commitment to offer you support.
- (12) Do writing your experience down on paper is also a helpful way to process your trauma.
- (13) Do seek a self-help group if you believe this would help you. In these group you will meet fellow survivors who are suffering but are able to communicate and share feelings with group members, and who are not so distressed they require professional intervention.

- (14) Do search for individual and/or available therapy groups with survivors of sexual assault-related trauma if your symptoms get worse and interfere with your life. Ensure that the group is led by a person with professional training and experience in rape trauma syndrome and PTSD.

- (15) Do all you can to engage in health-generating, mood-brightening activities:

Do reach out to others.

Do engage in meaningful hobbies, finding fun things to do.

Do put forth the effort to engage in regular physical exercise and relaxation procedures.

Do plan to eat well.

Do get sufficient rest.

Do learn how to reduce the “flightiness” (or being out of control) of your breathing.

Do things to normalize your life and its routines by having meals, sleep, work, and exercise at the same time of the day.

Do make a diligent effort to remain free of alcohol or drug use as ways of coping.

- (16) Resist eating heavy meals, drinking coffee, and intense physical exercise several hours before going to sleep.
- (17) Resist using anger to keep others away, as a “trauma technique” to remain safe from questions, safe from others’ piercing scrutiny, and from feeling vulnerable to the return of dissociated trauma thoughts, feelings, and behaviors.
- (18) Resist tendency to stay away from people, and from shopping malls, activities, and places you were accustomed to before the assault.
- (19) Resist tendency to make home into a defending fortress.
- (20) Resist making sweeping changes in your life at this time; for example, like moving away, changing careers, getting divorce, or dissolving long-term relationships—until, as they say, *further notice*.
- (21) Do remember that intrusive thoughts to the trauma are normal and predictable.
- (22) Do remember that your trauma intrusive thoughts are mere constructions of the mind; they are *not* real. That is, the recurring image or thought of the trauma does not mean the original traumatizing experience *is* reoccurring *in the present* as your mind-out-of-control would have you believe.
- (23) Do seek and get new knowledge about trauma and PTSD’s effect on your thinking, feelings, behavior, and on your perspective for the future. Knowledge is power, and information is truly how you get it. So, it’s also important for you to learn all you can about what happened to you, about your stress responses, and

- what you can expect whether you decide to deal with our ordeal alone, with friends, or by using professional assistance.
- (24) Resist the tendency among victims to use alcohol and drug to reduce anxiety and get sleep.
- (25) Since trauma responses take you away from the present, telling you that, despite the fact that you know the trauma is behind you, that, “in reality”, it’s still reoccurring in the present:

Do use relaxation skills.

Do use all your senses to *ground* you in the present. Thus,

Visually, focus on the color of objects in your immediate environment (“it’s green,” “long and sharp,” etc.). Keep your eyes open, and take note of where you are.

Auditorily, do focus on identifying the various sounds you’re hearing at the present time.

Tactilely, do touch objects close to you and describe the experience in detail. Touch something cold, warm, or hot and describe the sensory experience.

Olfactorily, do become aware of the various smells in your immediate environment.

Gustatorily, do think back at something you recently tasted, or select something to eat and describe the taste.

Do use *self-soothing* approaches:

Talk to your self in a reassuring language, reminding your self of who you are, where you are, and where you’re going.

Say compassionate things to your self.

Think of the last time someone said something that you found inspiring, and repeat it to yourself, now.

Remember your favorite poem and recite it.

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(26) Resist the tendency to reduce pleasure in your life.

(27) Resist becoming a workaholic to stave off memories of the trauma.

“I Am a Survivor!”: Now, How and When Do I Tell My Children About What Happened to Me?

Children can experience extreme distress and fear when a parent is traumatized by a rape, and witnesses the adverse/shattering impact of sexual victimization on parental attitude, mood, temperament, feelings, and behavior. When it comes to children, there is such a thing as *induced* traumatic anxiety they internalized in their interactions with a traumatized parent or surrogate. This inducing may occur during the acute phase of traumatic stress, or during the unraveling of latent traumatic responses in response to triggering devices.

Depending on the age and general level of maturity of the child she or he can be expected to do well as time goes on. Other children, however, may experience nightmares and sleep-time fears, requiring close proximity to parents. They may also regress to thumb sucking, bed-wetting, tantrums, and to other early-age behaviors and symptoms that interfere with academic performance.

Here are some things you can do to help children affected by living in a traumatic stress-primed environment.

- (1) Do all you can to ensure your children are not left alone with their feelings, and with unanswered questions, with confusion, anxiety, and distress.
- (2) Allow children to be in close proximity to you or significant family members or friends.
- (3) Provide opportunities for them to play, draw, and engage in play activities that allow them to process their distress over perceived parental behavioral changes, and deal with normal contemporary stress.
- (4) Children need to be able to talk about their feelings, particular their fears of the unknown, and to know that the affected parent will be OK and that they are loved, that this will not ever change despite the unsettling changes they have found in the trauma-affected parent.

- (5) Routinize (so as to normalize) the various daily activities of the family; for example, eating, sleeping, and recreational activities.

When Should I Seek Professional Help?

Some survivors are able to effectively manage the psychological, physiological, and interpersonal pressures through reaching out to family and friends, letting them know what you need. There are situations, however, in which your support systems may not be sufficient when you find your problems are getting severe and that you are not recovering from the traumatic experience as you had anticipated. Thus, if high levels of anxiety persist, depression does not improve, and the sense of helplessness seems to be getting worse, seek professional assistance. If the stress responses you are experiencing get in the way of your daily routine, interfering with your ability to give and receive love, attend to your family's general welfare, and perform adequately on your job, you may need to consult an experienced trauma mental health professional—psychologists, psychiatrists, social workers, or other professionals with experience in the successful treatment of sexual trauma survivors.

MILITARY SEXUAL TRAUMA (MST)

The issue of sexual military trauma is one of current cultural interest. Female and male soldiers become victims of sexual abuse while on active duty. Recent reports over the past year have sounded an alarm, and the need to pay attention to the problem of sexual victimization in military ranks has risen out of obscurity into the light of day. Rates of sexual harassment and actual sexual assault are significant for both women and men in past and current military service. Personal suffering is as real as if the abuse occurred in non-military contexts. MST can occur during peacetime as well as in war. In fact, there is belief and some evidence that this form of abuse may increase as a function of the stresses of war.

Many survivors may refuse to report these criminal incidents due to fear of reprisals, fear of being seen as a non-team player, a trouble-maker, fear of losing opportunities for promotion in rank, and fear of damaging a highly desired military career.

The Department of Veterans Affairs and the Department of Defense are aware of the needs of these victims and have taken decisive steps to provide services and compensation to women and men those who endure the degradation and distress associated with MST. Reports from various news organizations in recent months have brought to attention the high incidences of reported rapes and attempted rapes during the Global War on Terrorism (GWOT). It's a chief concern these days among trauma health care professional and organizations like the Department of Veterans and the Department of Defense, as well as civilian health care centers.

“OPEN SESSION”: PREVIEWING WHAT TRAUMA PROVIDERS THINK AND DO WHEN THEY TREAT PERSONS WITH SEXUAL TRAUMA

Searching For Effective Individual Psychotherapists and Caution

There are therapists of all stripes, persuasions, theoretical schools, clinical interests, and level of experience. Some therapists have a history of sexual abuse, others do not. The therapist's historical experience can either facilitate healing or undermine the treatment's potential. Even well-trained professionals in mental health may erroneously believe they can treat all forms of mental disorders, to include the intrinsic complexities and peculiarities of post-traumatic stress. The truth of the matter is that, when it comes to trauma and PTSD, only someone whose personality is sufficiently strong and cohesive, and has good training in general mental health, and additional specialized and supervision in trauma mental health can be trusted to facilitate the kind of integrative healing and reconstruction of lives torn asunder by sexual traumatizing violation.

Thus, trauma survivors beware! Today is it quite common for untrained mental health and even non-mental health providers to claim to have competence in the diagnosis and treatment of psychological trauma. This is to say that just because a provider has what appears to be a legitimate degree in mental health care does not means he or she knows what they are doing when it comes to intervening with sexual trauma survivors.

Searching For A Therapeutically Facilitative Group and Caution

It becomes the survivor's responsibility to reach out and do the necessary search for the therapist who possesses the qualifications, sensitivity, skill, temperament, and working congruence she or he feels will meet their needs. To find the right group and group therapist the survivor must shop for one, like shopping for a garment for a special gala event. The survivor may contact fellow survivors for leads, crisis centers, look through the yellow pages, or go online to find trauma therapists. Once a therapist is located, the survivor may interview the prospective therapist after constructing a questionnaire containing the specific issues the survivor deems essential before embarking on a therapeutic journey. The interview may be done by telephone or online. Some survivors may also want to know whether the therapist is a survivor, and whether the individual or group therapist has had their own therapy to help prep them for the complexities of the sexual trauma work they now practice.

Survivors who come to individual and group therapies seek insight, resolution, and relief from many critical problems they struggle with in their daily lives. They thus report:

- (1) nightmares, (2) broken sleep, (3) amnesia (concerning the event),
- (4) experiencing anxiety when in or around unfamiliar places, (5) discomfort with new people, (6) experiencing difficult in doing

multiple tasks at the same time, (7) experiencing difficulty in maintaining focus on one task at a time until completion, (8) struggle to stay in the present, (9) loss of peace, (10) perpetual sense of having to look over one's shoulder, (11) not being sure of one's feelings, with no clear sense of happiness or sadness; (12) not being sure what would restore happiness again, (13) at times afraid people will not understand one's behavior, (14) feeling as though no one can possibly understand what one is going through, (15) problem in communicating with others, (16) difficulty in expressing one's feelings and thoughts, (17) feeling alone when people are near, even loved ones, (18) distrust of others, especially of men, (19) cannot make eye contact with men, being forced to look toward the ground, (20) decrease in sexual desire, (21) tendency to overeating, and (22) tendency to sabotage positive efforts to improve one's life.

In the group treatment setting, the therapist and members listen to each other tell the tales of their own traumatic stress-related experiences and stress responses mentioned above. More often, survivors feel empty, disconnected, passive, and helpless. They search for a safe place with safety-engendering people who offer respect, and believability (pertaining to her or his narrative about what happened). The sense of being accepted despite the feeling of being “tainted” by violence and “feeling irredeemably unclean,” is a major early achievement of the group. The therapist serves as a healing-integrative bridge. This bridge is over troubled waters of internal traumatic torment and avoidant non-relating—traversing across the world of overwhelming abuse on one end, and the world of safety and health on the other.

Group therapy is frequently used as a healing strategy with survivors of sexual victimization. The group-as-a-whole organizes itself around intense conscious and unconscious perceptions, making available to its members opportunities to process negative relations, painful emotions, and fears associated with the sexual traumatic experience. The group works because it is able to construct a safe space, allows each member to experience self in a different way—in the presence of others, provide a powerful “gallery of mirrors” for survivor to see themselves in others' reflection. This achievement in the group often results in diminished avoidance, fear, and anxiety, and with increased sense of confidence and competence in interpersonal transactions.

Here's an important caveat we want to mention. Just as all individual therapy experiences are not alike, group therapy experiences are also not alike. By this we mean that not all groups will meet your needs. This is in part because groups may have potentially destructive overt or covert agendas that may not prove in the long run to offer the effective treatment victims feel is essential for dealing with their trauma problems. Some sexual trauma groups that do not work well for its members are those that focus exclusively on: the “badness” of all perpetrators, or on the “goodness” of all victims. The problem with the former focus is that group members get an unrealistic, one-sided view of the interpersonal world. Men are discussed in such a manner as to inadvertently

reinforce within the minds of women victims that all men “are potential rapists/abusers”, and that they should thus be on guard around men. This orientation renders havoc on victims’ contemporary intimate relationships. As time goes on, session after session, this negative agenda harms the healing process, deepening avoidance of intimate contact and desire, as well as potentially negative emotions like anger and resentment.

Focusing on the exclusive goodness of victims is also harmful, because, in the real world, people have both good and bad “parts.” When one is emphasized as passionately preferred over the other (rather than striving for the integration of the two), the trauma cannot be integrated toward resolution, and become consolidated around the center of the person’s identity and personality. Any untoward process that harms integration, essentially, fails to deal with anger, rage, dishonoring, transgression, and violation. These emphases or group agendas represent an undifferentiated perspective—seeing *all* men as “villains and potential victimizers,” or *all* survivors as “true victims, passive, ineffectual.”

Dr. Judith Herman of Harvard Medical School speaks on why the group works for trauma survivors, and on the importance of safety-maintenance in group therapy as a precondition for establishing goals, boundaries, reassurance, bonding, individual empowerment, and communal sharing. Maintaining that each trauma group creates its own collective meaning that contributes to the healing potential of the group, she writes, in her renown contribution to the trauma field, *Trauma and Recovery*, “The psychologist Erwin Parson ... invokes the metaphor of the platoon to convey the tight organization of the group: ‘The leader must be able to establish meaningful structure, laying out the group’s goal (mission), and the particular terrain (emotional) to be traversed.’”¹⁶

Additionally, the therapist presents self to the survivor as someone with whom it is possible to have a relationship, while demonstrating a capacity and credibility to provide essential safety. The therapist also ensures a balance is achieved over time between *revealing/exposing* (the survivor to traumatic memories and traumatizing relationships) and *growth-enhancing* (ensures not only getting over the trauma but achieving increase regulation to better manage memory, emotions, and behavior). The therapist is experienced by the survivors as a good, empathic listener, who is non-judgmental, honest, one who offers the survivor essential tools and corrective experience to enhance the feeling of being competent within, and empowered with an easiness and facility in relating to and being *with* people. Survivors’ relief often begins with the assurance they’ve found someone who is competent and able to make a difference in their lives.

Therapy Power: Transforming Emotion-Based Surviving Into Adaptive Problem-Focused Coping

Gaining Freedom From Trauma Authority: Discovering Power in Speaking the Unspeakable, and Bearing the Unbearable

Therapy has power. It offers a way out of the darkness that covers the lives of persons affected by sexual traumatization. Therapy transforms the negative effects of trauma when survivors learn that it is possible to take responsibility for the enterprise of therapy and move forward and win. We use the term “trauma authority” to bring attention to the well-known mentally enslaving phenomenon survivors experience as the pervasive “don’ts”—don’t think certain thoughts, don’t feel certain feelings, don’t go certain places, don’t talk about certain things. The power of therapy works to neutralize this internal state of trauma oppression. It encourages survivors to *develop confidence in their own judgment about their minds, bodies, and behavior* (lost due to the trauma) and to find power in speaking the unspeakable, and in bearing the unbearable burdens (affects) of transgressive abuse. Thus, therapy power gives new hope and capabilities to survivors. Sexual trauma is encoded in the mind, brain, and behavior, and shapes the subsequent expectations that all people, to include therapists, are not to be trusted because they tend to misuse power, knowledge, and gain one-sided, narcissistic gratification. When therapy works, it helps survivors to take responsibility for the problems that arise during the course of daily life.

Additionally, survivors gain increasingly mature perspectives that make it possible for them to assume the major responsibility for the enterprises of therapy and life. Additionally, survivors in therapy improve their ability to evaluate reality, and to make good, adaptive choices that are consistent with their pre- and post-trauma values—from a variety of options, choices that continually expand as one lives life in its own terms. Survivors also learn that through planning and goal-setting, they inspire personal commitment and learning from their experience which makes them even stronger and empowered.

Through open, trusting exploration of the nature of the sexual abuse with utmost sensitivity, the therapist invites the survivor to reduce trauma-defensiveness and resistance to growth, and open up to new possibilities of future health and freedom. This inner sense of post-trauma freedom emerges from honest mutual participation of survivor and therapist. The degree of details in terms of hidden thoughts, feelings, and impulses shared in this mutuality tells of the quality of the relationship. When the therapeutic relationship truly works the details of the traumatic episode are presented for mutual exploration—in terms of what *really* happened—internally and internally—during the event. The truth of what happened may include offender touching, oral sex, penetration, etc. It also includes the specific setting in which the abuse occurred. Did the abuse occur with a single adult, in a group sex setting, in ritual abuse, or in some other setting or situation? This degree of openness tells the survivor that therapy expects the narrowed, closed post-trauma life of the past to respond to new, healthy emerging experiences that widens and throws open the doors, releasing a vision of a potentially exciting future.

What the survivor gains from therapy is a new way of experiencing self—being in control of one’s life, being hopeful, feeling worthy of the good things of life, and

experiencing the sense of being competent to live. Moreover, therapy assists survivors in modulating arousal, irritability, and anger, as well as in regulating inner sense of equilibrium, and tendency to withdraw from others, seeking dead-end, ineffectual safety that goes nowhere and does no good. Knowing that female crime victims tend to “hold in” anger, according to research studies, the therapist makes a concerted effort to help survivors deal effectively with pent-up anger.

Assertive behavior is a very important outcome of effective therapy for sexual trauma survivors. Being assertive means that the survivor has learned that she or he does not need to explain their intentions and behavior to anyone; they learn that it's OK to change their minds, and that it's alright to say one does not know something. They also learn they have the perfect right not to like someone, and to say “No!” without guilt, remorse, shame, and self-defeating behaviors.

Generally, through recognizing the reality of how survivors deal with unpleasant, unwanted traumatic memories by ignoring, distorting, and forgetting them, therapy also enhances survivors' coming to terms with these private unwanted events. Treatment offers freedom from dysfunctional emotion-based survival strategies by enlarging the survivor's self capacity to bear the traumatic burdens of mind and body, as well as to continually expand the repertoire of adaptive, solution-oriented coping strategies.

Lazarus and Folkman proposed that there are two basic kinds of coping; each one is employed based on the individual's perception of control over the stressor, and appraisal of the level of threat posed by the stressful situation.¹⁷ The survivor who sees the traumatic experience as outside his or her control is likely to use emotion-based coping, while the individual who views self as in control employs adaptive coping.¹⁸ Therapy offers hope to sexually traumatized survivors because it is very effective in increasing the survivor's capacity to trade in ineffectual emotion-based coping for the more adaptive problem-focused strategies.

In their work, Brand and Alexander further refine Lazarus and Folkman's two modes of coping. They note that the emotion-based strategy involves avoidance, distancing, self-blame, and problems in controlling one's feeling, and the adaptive problem-focused strategy which consists of confrontation, seeking social support, and planning how to actively respond.¹⁹

The trauma enlightened therapist also recognizes that her or his feelings toward the survivor may help or impede the therapeutic enterprise. Many therapists are themselves survivors, and as such might find their patient's problems to be overwhelming, especially if the therapist has not come to terms with personal trauma. The terms “compassion fatigue”²⁰ and “vicarious traumatization,”²¹ are used to reflect non-survivor therapists' traumatic stress responses to the work they are doing with their patients. Therapists thus understand the necessity of engaging in self-care in their trauma work.

Making Essential Healing Connections and Reconciliation with Past Horror

Since the horrific effects of trauma were brain-altering, self-shattering, meaning-undermining, connection-severing, *dysorder-creating*, faith-ruining, and control-subverting, traumatherapy assist the survivor in making vital connections and reconciliation essential for long-term recovery and integration. Exploring trauma history in a relationship that is experienced as safe and promoting openness and non-resistance facilitates the essential emotional connecting between the past and present, between self and world (family, friends, community, nation, and beyond, to include between the survivor and non-survivors worlds), and reconciliation of pre- and post-trauma identities, consolidation.

Post-Trauma Self-Augmentation

Personal growth or what we call “post-trauma self-augmentation,” is also an important outcome of surviving sexual trauma. Though most discussions on the impact of psychological trauma focus exclusively on symptoms, illness, and dysfunctions, there an increasing body of evidence which shows that people get stronger, become more effective in living, and develop better attitudes toward self, others, the world, and the future. Studies and observation found that about 50-60% of the sample reported some positive change following a variety of traumatic events. Borrowing from the work of Tedeschi & Calhoun,²² Frazier, Conlon, Tashiro, & Sass concluded that sexual assault victims experienced post-traumatic growth similar to victims of other traumatic events. They found positive changes as early as two weeks postassault—80% showed altruistic concerns for other survivors, 46% had greater appreciation for life, 46% a more positive view of family members.²³

The study also found such trauma-acquired positive attributes like empathy for others, advances in self-view, such as increased assertiveness, and positive changes in spirituality or life philosophy, such as greater appreciation of life. The study also found that when victims focused on the present, post-traumatic growth was greater than when they settled into a focus on the past. This growth was more related to a present/future-affirming orientation than one of denial and disavowal of the trauma.

Generally, clinical experience, research, and observation over the years reveal post-trauma self-augmentation represents an expansion that is dialectically opposite to the narrowed, constricted life trauma victims are forced to live in.²⁴ Some of these positive growth-oriented gains are:

- (1) Feeling closer to family.
- (2) Feeling closer to friends.
- (3) Increased in appreciation for life.
- (4) Discovery of meaning in life.

What Survivors Say They Found Personally Useful About

Their Experiences in Therapy

As a positive outcome of traumatherapy, survivors often report the things they found helpful in their treatment, those things that made them adaptive problem-focused copers: Among the positive therapy experiences found helpful by survivors are:

- (1) Realizing one is not alone, that one's experienced distress is shared by others.
- (2) Reducing the sense of being strange/different from others.
- (3) Sharing emotions, memories, and behaviors with someone who is nonjudgmental.
- (4) Getting meaningful support and encouragement to go forward and do the hard work of memory and emotional processing in therapy.
- (5) Re-establishing trust in others.
- (6) Re-establishing trust in one's own body, mind, and judgment.
- (7) Becoming more assertive.
- (8) Improving self-esteem and self-worth.
- (9) Improving social interaction.
- (10) Knowing, understanding, and appreciating the truth that she or he did nothing wrong, and therefore is not to be blamed, and that she/he, at no time, had ever expected, encouraged, nor sanctioned the abuse.
- (11) Improving effective communication skills in expressing feelings and emotional needs and concerns.
- (12) Reducing in frequency and intensity of nightmares.

These and other improvements came about as the survivor took action despite fear (courage), and persisted in the following healing activities:

- (1) Attending therapy on a regular basis.
- (2) Following through on specific assignments to create specific outcomes (e.g., assertiveness).
- (3) Engage in regular physical exercise.
- (4) Engage in weight management, when needed.
- (5) Expand survivor's interest and development of innate potentialities through returning to college.
- (6) Volunteering in community organizations.
- (7) Staying positive: surrounding self with positive people and things.

Other Desirable Benefits of Traumatherapy

Psychotherapy is preeminently positioned among a variety of possible avenues to increased positive coping and integration after sexual trauma. It's a powerful option in survivors' post-traumatic armamentarium to fight and take back their lives. Psychotherapy aims to provide:

- (1) a *correcting emotional experience* (to repair the shattering damage to the self caused by the trauma),
- (2) the *making of choices* for change (to overcome the peritraumatic experience of uncontrollability),
- (3) a *modeling* of human relationship as a means of change,
- (4) a *replacing* of maladaptive habits by adaptive ones,
- (5) *restoring* of diminished morale,
- (6) the *establishing* of new learning about *human relationships*,
- (7) the *instilling* of desire and hope,
- (8) the *restructuring* of maladaptive problematic thinking patterns,
- (9) the *modifying* of maladaptive patterns of action.
- (10) the *integrating* of repressed, dissociated, projected, and denied ideas, feelings, and memories so they no longer hijack your freedom, as you new creative energies now available to assist in solving problems that get in the way of your living life on its term.
- (11) the *understanding* and appreciating one's history in order to claim the present and build a positive post-trauma future of hope and confidence.
- (12) the *transforming* of transgressive distress.²³

Therapy makes it possible, moreover, for survivors, once overcome by the trauma, experienced their own muted voices that were unable to find the language to utter their pain in a manner it would be understood by others. Survivors often cannot find a consensually validated language to tell their narrative. Victims need to testify because they've been tested, and have something of value to say to the world. Therapy helps here as well: the victim always has a story to be told, and *must* be told to someone, sometime, to one who is experienced as trustworthy, supportive, with a facilitating presence. Survivors thus find it essential to be able to tell their own narrative as a healing strategy. Another important healing strategy after sexual victimization is acquiring the capacity to love one's self. Traumatized women learn how to love themselves—a difficult feat after trauma.

Most Popular Procedures Used By Trauma Experts with Sexually-Traumatized Persons

The most popular techniques take into account the complexities of trauma and PTSD responses. When trauma strikes the survivor's mind and body goes into gear to ensure survival by mobilizing neurobiological mechanisms. These changes result in what psychologists call an emotional conditioned response or fear conditioning. First, there is the overwhelming event, then the emotional response which become conditioned to the traumatizing stimuli. Here, the traumatic event is linked to the emotional response. Therapy helps victims disconnect the powerful emotional conditioned response (fear) from trauma memories.

The therapist often begins by considering why the survivor is coming to therapy at this time. What precipitated the post-trauma crisis? Most people coming to therapy come due to a state of crisis; very few come for help because of some deep awareness of

the importance of working through the trauma. Usually, the therapist learns that triggering devices vary from survivor to survivor. For example, rape victims may experience a crisis when a child—a son but especially a daughter—becomes sexually active, war veterans may react with intense anxiety due to wars and rumor of wars such as in Iraq and Afghanistan. The therapist also assesses the nature of the psychiatric emergency, attending to the degree of depression, suicidal or homicidal ideation, and the misuse of alcohol and drugs (prescribed or “street”). If the survivor seems to be out of control, PTSD will not be the first problem addressed. The survivor would benefit here from a stabilizing regimen of care. PTSD may become the central focus of therapy as time progresses and the survivor gains stability.

Most trauma experts conceive interventions as consisting of an individualized treatment plan that integrate psychological, spiritual, biological, social, and community elements. Thus, the therapist organizes the treatment plans to incorporate the survivor’s heightened autonomic arousal, the natural tendency to avoid confronting trauma memories and perceptions, and other brain function abnormalities that control sleep, aggression, cardiovascular activity, anxiety, and mood.

When the survivor comes to therapy and embarks upon a journey of healing, there are a number of techniques and approaches trauma experts widely recognize and use to ameliorate and resolve traumatic suffering and foster integration. Here is a very pertinent statement that tells of the fundamental damage to the self wrought by trauma and a guide to intervention. After trauma Pierre Janet noted that the survivor was *attached* to the trauma, “unable to integrate traumatic memories,... [a] lost ... capacity to assimilate new experiences.... [the] personality definitely stopped at a certain point and cannot enlarge any more by the addition or assimilation of new elements.”^{25, p. 532}

Trauma treatment encourages the adaptability of the self, allowing “assimilation of new elements” that reactivates development. In the context of trauma integration, ethnocultural identity issues are naturally implicated in the healing process, since what therapy aims to integrate is not only specific trauma memories and emotions, but the fundamental architectural design of the self or personality.

Because psychological trauma fragments the self (survivors usually describe their lives as “in pieces,” or as in “the pieces not fitting together as they once did), taking away its coherence and integrity, treatment aims to restore the sense of wholeness and integration—the harmonizing of diverse aspects of the self. Trauma disintegrates (making it difficult to come to terms with an upsetting event and allowing it into one’s autobiographical memory); treatment integrates. The overarching goal of treatment is to foster integration. Integration is akin to *healing*, which means “to make whole.” The following techniques represent the most often used approaches in helping survivors in contemporary traumatherapy for sexual victimization.

- (1) **PTSD Education.** This treatment element will help you manage the tendency to self-blaming and self-doubting seen in survivors, normalize post-trauma responses by understanding the nature of trauma and PTSD, and the adverse effects these

have on your behavior and general well-being. As knowledge unfolds during the course of trauma education you will learn about possible triggering events and residual effects, as well as about flashbacks, relapse prevention, discrediting myths, and introduction to general self-care.

- (2) **Cognitive-Behavior Therapy (CBT).** This set of procedures help you to overcome the negative conditioning you acquired as a consequence of sexual trauma by learning how to disengage fear from instigating reminders. CBT has a two-step process that recognizes that (1) *fear* is conditioned at the time of the trauma, so that any stimuli associated with the original trauma is able to evoke intense fear responses, and (2) *avoidance* of any stimuli is geared to control fear. Because avoidance ensures a sense of calm and safety, it is reinforced over time.

(A) **Cognitive Therapy (CT).** Here the survivor learns to change irrational, distorting beliefs that maintain and reinforce traumatic distress by weighing the evidence and then using reality-based alternatives. This technique will help you to become aware of and ultimately control your automatic thoughts and how they maintain trauma-based thinking, feelings, and behavior.

(B) **Anxiety Management (AM).** This procedure consists of a wide variety of techniques—relaxation training, breathing retraining, positive self-talk, thought stopping (distracts distressing thoughts), and assertiveness training (making one’s wishes and preferences known in an interpersonally adaptive manner).

(C) **Acceptance and Commitment Therapy (ACT).** Called “ACT” (as opposed to “A-C-T”), this type of behavioral treatment approach begins with the fundamental observation that human beings find it inordinately difficult to be happy, and that the pervasiveness of human suffering is seen the multiplicity of DSM system diagnoses and research findings on such maladies as suicide, high rates of divorce, sexual abuse, and violence. The technology and theory of ACT focus on “functional contextualism”—a focus on the whole event, understanding of the function of the event within a context, and a pragmatic truth criterion.²⁶

In ACT behavioral change occurs when the individual *accepts* the painful private events associated with the trauma rather than resist them (this form of control is said to be *the* problem). Acceptance is viewed as a conscious decision on the part of the trauma survivor to abandon a change agenda that has not worked, and to “experience events fully ... without defense ... as they *are*.”^{27, p. 30}

In terms of trauma treatment, ACT uses the concept of *experiential avoidance* to highlight the critical problem that has to be addressed in traumatherapy. Acceptance is the alternative to the futility of emotional avoidance. Acceptance ultimately helps the survivor contain private trauma events in a dispassionate manner that gives

support to resolution. Here the individual chooses “being willing” over “feeling willing.”

ACT employs a variety of concepts such as (1) “creative hopelessness” by which the person realizes the futility of prior efforts in dealing with his or her problems, (2) “control of private events as the problem” in that such efforts serve as barriers to successful effort, (3) “I as content vs. I as context” by which in part the self is differentiated from negative trauma programming, (4) “letting go of the struggle,” and (5) “making a commitment to action” that fulfills the individual’s chosen values and goals.

- (D) **Systematic Desensitization (SD).** This technique will help you to replace anxiety with the relaxation response.
- (E) **Stress Inoculation Training (SIT).** This technique will help you learn a number of coping techniques in order to provide you with the critical sense of mastery, to include opportunities to practice the skills in a graduated manner. SIT would be tailored to meet your individual needs directly.
- (F) **Exposure Therapy (ET).** Here you are assisted in the very important recovery task of confronting memories, emotions, objects, people, places, and things that are associated with the intense fear you feel. You would be expected to repeatedly go over the traumatic emotions and memories until the once fear-inducing memory no longer evokes fear and anxiety.
- (G) **Cognitive Processing Therapy (CPT).** These techniques focus on thinking and feeling processes associated with the trauma, and ameliorates anxiety by deconditioning troublesome thoughts, feelings, and memories of the trauma. You would be asked to write your own narrative or autobiographical sketch and so learn to gain control the degree of re-exposure.

(3) **The Counting Method.** The Counting Method (TCM) is a trauma therapeutic technique devised by Frank M. Ochberg, M.D. to prevent or modulate traumatic memory and associated dysphoric mood, to include terror, fear, and helplessness. It was also designed to enhance trauma victims’ ability to learn how to master the emotional stress responses and disordered behavioral manifestations of trauma. Organized within a larger domain of clinical interventions called *Post-Traumatic Therapy*, TCM features a relative short history of outstanding results with trauma victims. The therapist counts out loud to 100, while the survivor focuses on and relives a haunting memory and experience associated emotions.

There therapeutic action or mechanism of TCM is said to be the linking of problematic, distressing memories with the therapist’s voice and to the experience of the therapeutic partnership, offering integrative reassurance, trust, and capacity to persist in memory work.

TCM features some elements of EMDR (to be discussed below), in that it pairs the therapist's activity with unwanted traumatic memories, while fostering relaxation during remembering, and tolerating intense emotions as key therapeutic devices.²⁸

(4) EMDR (Eye Movement Desensitization and Reprocessing). This approach integrates a number of treatment techniques, to include psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies. In the therapy the survivor is instructed to focus on past and present experiences while simultaneously focusing on an external stimulus. Organized in eight phases, EMDR incorporates an understanding of trauma history, teaching relaxation skills, identifying vivid images associated with trauma memories, a negative belief about the self, and related bodily sensations and related emotions, a preferred positive belief is identified. Therapist then asks the survivor to focus on the image, negative thought, and body sensations, while moving his or her head following the therapist's fingers move across the field of vision for 20 to 30 seconds or more. This procedure is repeated several times during the session. The therapist then engages in closure, requesting the survivor keep a trauma journal, and continues doing calmative techniques. At the last phase, the treatment process is re-evaluated and progress noted.²⁹

(5) Drug Treatment (Psychopharmacology). There a number of medications physicians informed in the area of traumatic stress can offer you. Many doctors use the SSRIs (Selective Serotonin Reuptake Inhibitors) as preferred choice in treating PTSD. Among these agents are: Zoloft, Paxil, Prozac, Luvox, Serzone, and Effexor. Other medications to help survivors of sexual victimization with PTSD include tricyclic antidepressants (like Elavil), but the side effects makes them less preferable to the SSRIs. Mood stabilizers are also used with some survivors to deal with emotional instability, while anti-anxiety medications are used to help ameliorate anxiety (such as Valium, Xanax, Klonopin, and Ativan. Because these medications are Benzodiazepines and are highly addictive, they are ideally used with caution for a brief period of time. Another class of medications called MAOs (monoamine Oxidase Inhibitors (MAOs), are regarded to be more beneficial than the TCAs, because MAOs reduce intrusive thoughts, nightmares, and flashbacks, as well as improves sleep.³⁰⁻³¹

The clinical decision in terms of which services, procedures, and techniques are best suited to meet your needs is made by mental health providers who are experts in the study and treatment of PTSD and associated psychological conditions. The approaches chosen may differ from one provider to another, from one survivor to another, depending on the age, specific trauma symptoms, and degree of impairment.

Professional trauma therapists understand that each survivor in therapy is unique, that all rape or incest survivors are not alike, despite the impression given by many writers in contemporary trauma literature. People in therapy for sexual trauma are distinguished from one another by their unique trauma histories, by their unique personalities and coping choices, and by differing pre-trauma, post-trauma, social, political, and economic experiences.

Experienced sexual trauma therapist understand that survivors may be “repeaters” due to a prolonged period of acute symptoms, exacerbation by both intrapsychic and environmental memory-activators. Many leave treatment prematurely before the deeper clinical concerns are explored and addressed. This, in our experience, may be due to survivors’ low tolerance from strong affective generated during the normal course of memory processing. In some instances, the survivor’s persistent presentation of acute symptomatology is due to mini-retraumatizing experiences which prevent underlying stress response processes from being worked through to completion and integration.

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CHILDHOOD AND ADULT SEXUAL VICTIMIZATION:
Living in the Aftermath of Transgression and Quest for Restoration of the Self

Victims of Disasters: Helping People Recover From Acute Distress to Healing and Integration

Inner City Children of Trauma: Urban Violence Traumatic Stress Response Syndrome (U-VTS) and Therapists' Responses

Stress Responses in Sexual Trauma Victims and in Others Experiencing Overwhelming Events
Helpful Strategies for Self, Children, Supporters, and What Trauma Therapists Really Do

Online Resources:

Gift From Within (www.giftfromwithin.org)
The Gateway to PTSD Information (www.ptsdinfo.org)
International Society for the Study of dissociation (ISSD, www.issd.org)
International Society for Traumatic Stress Studies (ISTSS, www.istss.org)
National Center for Post-Traumatic Stress Disorder(NCPTSD, www.ncptsd.org)
Sidran Institute (www.sidran.org)
National Organization For Victims Assistance (NOVA)
www.trynova.org
Children’s Crisis Treatment Center
www.cckids.com
Center For Traumatic Stress Research
www.uku.edu/education
www.stoprape.com
www.uiowa.edu.rvap

Books on Sexual Trauma and healing

From Child Sexual Abuse to Adult Sexual Risk: Trauma, Revictimization, and Intervention, by Linda J. Koenig, Lynda Doll, and Ann O'Leary.

Broken Boys/Mending Men: Recovery from Childhood Sexual Abuse, by Stephen D. Grubman-Black.

The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse, by Ellen Bass, Laura Davis.

I Never Told Anyone: Writings by Women Survivors of Child Sexual Abuse, by Ellen Bass, Louise Horton.

I Cant Talk About It: A Child's Book About Child Abuse, by Graci Evans, Doris E. Sanford.

Male Survivors of Rape or Sexual Assault, by John La Valle.

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