After the Crisis Initiative: Healing from Trauma after Disasters

Resource Paper:
Trauma and Retraumatization

Nina Kammerer and Ruta Mazelis

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Trauma

The trauma that is the focus of the "After the Crisis: Healing from Trauma after Disasters" initiative is not the trauma of emergency medicine – traumatic bodily injury, whether from accidents, beatings, or disasters – although it certainly intersects with such injury. A distinction is often made between a traumatic event and "psychological trauma" (e.g., Herman, 1992b), the impact on the individual of experiencing a traumatic event. Frequently, the word 'trauma' is used as a short-hand for both. Attention is paid in the literature to distinguishing between traumatic life events and stressful life events, with the line often drawn, in keeping with the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), between those events that involve "threat of death or serious injury" and, according to the current edition of the *DSM* (DSM-IV-TR [Text Revision]) (American Psychiatric Association [APA], 2000), also an "emotional response of fear, helplessness, or horror at the time of the precipitating event" and other "painful and stressful events that constitute the normal vicissitudes of life, such as divorce, loss, serious illness, and financial misfortune" (McHugo et al., 2005a, p. 114-115). Today's world is replete with examples of extreme life events, including war, ethnic cleansing, genocide, terrorist attacks, as well as tsunami, earthquakes, floods, tornadoes, and hurricanes – so-called "natural disasters" whose impact is frequently shaped by past and present human actions and inactions.

Following SAMHSA's Women, Co-Occurring Disorders, and Violence Study, we use the word 'trauma' to mean interpersonal violence in the form of physical abuse and sexual abuse, including childhood sexual abuse, rape, and domestic or intimate partner violence. Such trauma may or may not entail trauma in the medical sense of traumatic bodily injury. We understand violence in the sense of violation, which may or may not entail physical violence against a person but ***always*** entails violation of that person. In addition, the term 'trauma' can designate neglect or verbal, emotional, or psychological abuse, which some consider even more damaging than interpersonal physical and sexual abuse (Dutton, Kaltman, Goodman, Weinfurt, & Vankos, 2005; Follingstad, Rutledge, Berg, Hause, & Polek, 1990; Savin-Williams, 1994), as well as stalking (Basile, Arias, Desai, & Thompson, 2004), and witnessing interpersonal violence (American Psychiatric Association, 2000). We also use the word 'trauma' to designate the impact of traumatic events on individuals. Thus 'trauma' designates both events and their impact, in part because the actual experience of abuse and the assault that experience poses to sense of self, safety, belonging, and connection are intertwined.

Living through traumatic events changes the ways the self and the world are experienced. In the words of Judith Herman (1992b, p. 135), "[t]he core experiences of . . . trauma are disempowerment and disconnection from others." Alternatively phrased, trauma as event – or events – creates trauma as experience**,** at the center of which is damage to individual agency, "self-in-relation" (Miller, 1976), trust, and safety. We designate the effects of trauma as its "impact" because this singular term reminds us that human trauma, though often multiple in its manifestations, is unitized in arising solely from traumatic events and requires helping responses which, however manifold, should be uniform in being "trauma-informed" (Fallot & Harris, 2001; Harris & Fallot, 2001).

From the passage just quoted from Judith Herman, we left out the word 'psychological' as a descriptor of the word 'trauma'. Calling the impact that traumatic events have on individuals "psychological trauma" fits nicely with the biomedical model with its sharp division between body and mind and its erasure of the spiritual or religious; it also fits nicely with the individualizing tendency of Western culture in general and of biomedicine in particular (Conrad, 1975; Farmer, 2004; Scheper-Hughes & Lock, 1987; Zola, 1972). It also participates in the pathologizing through which medicalization transforms problems into diseases and disorders (Conrad, 1975; Estes & Binney, 1989; Gilfus, 1999; Zola, 1972). Perhaps partly because the word 'trauma' is embedded in the diagnosis but also for other complex reasons, "psychological trauma" is too often equated solely with Post-Traumatic Stress Disorder (PTSD).[i] In omitting this term from the quotation from Judith Herman's celebrated *Trauma and Recovery*, we do not deny the existence of psychological trauma, including PTSD (Young, 1995), but mean to underscore that not every impact of trauma is psychological in the sense of mental health diagnoses or labels.

If we see all trauma in exclusively psychological terms, our questions will be framed in psychological terms and the answers we get from those who experience trauma will be framed in that way. Ashraf Kagee, a South African psychologist, demonstrated this in his qualitative study of the impact of torture on men and women imprisoned during the Apartheid era. Wary of "the effect of demand characteristics," which is just a technical way of saying that questions shape answers and therefore shape what we learn, he chose not to administer a standardized clinical checklist, questionnaire, or structured interview tied to diagnostic criteria. Instead he asked a series of "open-ended questions to learn participants' understandings of the ways that their experience of abuse has affected or is presently affecting their lives" (Kagee, 2004, p. 627). Unprompted by specific questions, study participants mentioned symptoms eleven times that can be construed as psychological and, indeed, meet PTSD diagnostic criteria (see Table 2 of Kagee, 2004, for complete data). Much more frequently, however, they spoke about "[g]eneral health concerns," current "economic concerns," and "dissatisfaction with the present political situation in South Africa," all of which they related to their experience of trauma and all of which would not have been revealed had the interview been restricted to clinical questionnaires (Kagee, 2004, p. 627-628).

Turning our attention at the outset to terminology is not to engage in intellectual nit-picking or academic deconstructionism; neither is it our intention to introduce political correctness, stipulating the use of certain terms and banning the use of others. Rather, we want to draw attention to the fact that words are powerful and to invite us all to be mindful of what meanings we intend and what meanings we unintentionally import through our choice of words. The words we use shape our understanding of problems and our vision of solutions. Helping responses should focus on the self as situated in social bonds of family, friendship, and community rather than simply the psychological self, and interventions should include community and peer support rather than simply clinical treatment (see *From Relief to Recovery: Peer Support by Consumers Relieves the Traumas of Disasters and Recovery from Mental Illness* resource paper).

Types and Prevalence of Trauma

Trauma experienced by an individual can be a single event – ***a*** beating, ***a*** molestation, ***a*** rape – or it can be repeated events – beating***s***, molestation***s***, rape***s*** – over days, months, or years. Lots of adjectives have been used to describe such repeated trauma, including "prolonged," "repeated," "chronic" (Herman, 1992a, p. 377, 385), "cumulative" (Turner, Finkelhor, & Ormrod, 2006, p. 13; see also Turner & Lloyd, 1995), and "multiple" (Classen, Palesh, & Aggarwal, 2005, p. 103). When the traumatic stressor is war or other conflict situation, trauma has been called "continuing" (Straker & Moosa, 1994). Others have expanded the application of the word 'trauma' to include "stigma trauma, that is, trauma that results from membership in a despised or oppressed group" (Fullilove, Lown, & Fullilove, III, 1992, p. 275) and "historical trauma" in the form of "colonial domination of Native peoples" (Saylors & Daliparthy, 2005, p. 274; see also Yellow Horse Brave Heart, 2003) or enslavement. M. T. Fullilove (as quoted in Levenson, 2004, p. 179) argues persuasively, with documentation from lives devastated by despair and crack, that "in the process of contagious housing destruction," which occurred in US inner cities in the 1970s and 1980s when what Wallace (1988) calls "planned shrinkage" of fire services was followed by the destruction of neighborhoods through fires and building abandonment (see also Fullilove, 1999-2000; Fullilove, Green, & Fullilove, III, 1999; Wallace, 1988, 1989), "what happens to you is trauma" (as quoted in Levenson, 2004, p. 179).

Since the 1970s, when interpersonal violence in the United States began to get public attention and greater documentation – in part due to the Women's Movement – a body of literature has been produced that amply documents the horrifying prevalence of such events (Straus, 1992). Types of trauma include child neglect, childhood physical abuse, childhood sexual abuse, and rape, as well as intimate partner or domestic violence, both in heterosexual and in same-sex relationships (Stopp, 2003, 2005). Perpetrators are both men and women, often precisely those who are supposed to be protectors or partners. Trauma is democratic in that both perpetrators and individuals who suffer interpersonal violence are diverse in socioeconomic level, educational attainment, geographical residence, and racial/ethnic affiliation. Nevertheless some patterning is evident. For example, trauma can occur at any point in the life cycle, but evidence suggests that it is more common during childhood, adolescence, and early adulthood (Macmillan, 2001), and people who are poor and belong to minority groups are disproportionately affected by the trauma of living in devastated inner city neighborhoods (Fullilove, 1999-2000; Fullilove et al., 1993; Fullilove et al., 1999; Romero-Daza, Weeks, & Singer, 2003). Citing a 1995 study by Kessler et al., Najavits, Schmitz, Gotthardt, & Weiss (2005, p. 425) report that men have a higher lifetime rate of trauma than women (60.7% versus 51.2%, respectively), but the types of trauma experienced differ, with "witnessing of someone badly injured or killed, natural disaster, life-threatening accident, physical attack, combat, threat with a weapon, and being held captive or kidnapped" more common among men than women.

Information on the prevalence of trauma is now available not only from clinical samples of people who intersect with the mental health or substance abuse service systems and criminal justice samples of incarcerated individuals, but also from primary care samples and community samples. Data on frequency does not always distinguish between single event trauma and repeat or continuous event trauma; data on age of occurrence – or age of onset for repetitive trauma – is sometimes available, with attention paid to childhood versus adolescence or adulthood, although "age demarking childhood from adolescence and adulthood has varied across studies" (Muehlenhard, Highby, Lee, Bryan, & Dodrill, 1998, p. 2).

Two National Family Violence Surveys, conducted in 1975 and 1985, respectively, "found very large decreases in both child abuse and wife beating" (Straus, 1992, p. 222). Yet, despite these decreases, in 1985 there were "a minimum estimate of over a million abused children aged 3 through 17 in two-parent households" and "over a million and a half beaten wives each year in the United States" (Straus & Gilles, 1986, p. 475). In a sample of individuals 15 or older, the Ontario Health Survey found a prevalence rate for severe childhood sexual abuse of 11.1% among females and 3.9% among males (Margolin & Grodis, 2000, p. 447-448). It has been estimated that 10 million children in the US witness physical violence between their parents in a given year (Margolin & Grodis, 2000, p. 448). According to the National Crime Victimization Survey (2006), in 2004, one rape or sexual assault occurred for every 1000 people in the US. In four national studies of rape of women, prevalence rates ranged from 15% to 36% (Campbell, 2002, p. 118). According to Finkelhor (1994, p. 37), "prevalence studies have led most reviewers to conclude that at least one in five women in North America experienced sexual abuse (either contact or noncontact) during childhood;" whereas, aside from one prevalence estimate of 16% (Finkelhor, Hotaling, Lewis, & Smith, 1990), "the range of other community studies about males tends to be between 3% and 11%" (Finkelhor, 1994, p. 37).

The Impact of Trauma

Partly because PTSD is the most widely known impact of trauma but also for other complex reasons, trauma's impact is often seen in terms of symptoms of psychological disorders. Dissociation, flashbacks, and nightmares that are among the diagnostic criteria of PTSD are not the only symptoms associated with experiencing violence designated by mental illness diagnoses. Diagnoses of depression, anxiety and panic disorders, obsessive compulsive disorder, psychotic disorders, and eating disorders are commonly given to individuals who have experienced violence (Allen, Huntoon, & Evans, 1998; Briere & Elliott, 1994; Browne & Finkelhor, 1986; Margolin & Gordis, 2000). Antisocial personality disorder, in which anger is externalized in the form of aggression, is diagnosed more frequently among men than women with histories of trauma; among women with such histories, a more common diagnosis is borderline personality disorder, which can be characterized as an internalization of anger (Stewart & Harmon, 2004, p. 251), as well as by self-inflicted violence (a commonly misunderstood coping strategy for the repercussions of trauma) (Mazelis, 2003).

Studies have repeatedly shown that substance abuse is correlated with a history of physical and/or sexual abuse, with drugs and alcohol often serving as self-medication for the experiential impact of trauma (e.g., Blume, 1990; Brown & Anderson, 1991; Covington, 1996; Fullilove et al., 1993; Herman 1992b; Miller 1994; Reed & Leavitt, 1996). In a study of out-of-treatment African American drug users, 42% reported having experienced a traumatic event; among men, this correlated with early onset marijuana and heroin use (Johnson et al., 2006). The links between trauma and substance use are many and complex. Using substances can make women more vulnerable to rape or other violence and may lead them into prostitution or exchanging sex for drugs (Carlson & Siegal, 1991; Fullilove et al., 1992). Yet for many women, abuse as children or youth preceded their problems with alcohol or drugs and any physical or sexual abuse they experience as adults (Cohen et al., 2000; Zierler et al., 1991).

Among both men and women with histories of trauma, substance use and symptoms designated "mental illness" often co-occur. For example, an estimated 38% of men in substance abuse treatment have PTSD (Najavits et al., 2005), and the Substance Abuse and Mental Health Service Administration's Women, Co-Occurring Disorders, and Violence Study readily recruited 2,729 women who had experienced physical and/or sexual abuse and also had both substance use and mental health diagnoses (Becker et al. 2005, McHugo et al. 2005b). In a sample of 78 homeless individuals diagnosed with co-occurring substance abuse and mental health disorders, 100% of the women and 68.6% of the men reported lifetime experience of trauma (Christensen et al., 2005; see also *Criminal Justice Systems Issues and Response in Times of Disaster* resource paper for an overview of research on the prevalence of trauma histories, substance abuse, and mental health issues among incarcerated individuals.)

Trauma, both past and present, is also associated with risk for sexually transmitted infections (STIs) (Romero-Daza et al. 2003; Saylors & Daliparthy 2005). Among a study sample of 393 individuals recruited through an HIV counseling program, 28% of women and 15% of men reported having been sexually assaulted as a child (Zierler et al., 1991). Those who reported childhood rape were nearly three times more likely to be in prostitution than those who did not, and men who reported childhood sexual abuse were twice as likely to be HIV-positive than men who did not (Zierler et al., 1991).[ii] Intravenous drug use, which has been shown to be associated with childhood abuse (Felitti, 2002), is not the only substance-related risk for infection with HIV or other STIs. Crack use elevates such risk partly through the exchange of sex for drugs propelled by the "binge nature of crack use" (Green, Fullilove, & Fullilove, III, 2005, p. 28), but also because during oral sex, burns around the mouth caused by smoking the drug can facilitate transmission (Carlson & Siegal, 1991; Fullilove et al. 1992). Alcohol use has been shown to be linked with sexual risk in complex ways (Santelli, Robin, Bruner, & Lowry, 2001). A history of trauma is also associated with bodily pain (Bassuk, Dawson, Perloff, & Weinreb, 2001), chronic fatigue (Taylor & Jason, 2002), poor body image (Campbell & Soeken, 1999), and common serious illnesses such as cardiovascular and auto-immune diseases (Anda, 2004).[iii]

In all of these studies the impact of trauma is most easily captured in symptoms labelled psychological or physical. Less easy to capture, much less to quantify, are lack of trust (Sadavoy, 1997), fear of forming relationships, and lack of ease in one's being (Briere & Elliott, 1994) – the disorientation and disconnection that trauma creates (Saakvitne, 2000). Such impact is difficult to describe but not difficult to understand, especially when we consider that many perpetrators of childhood sexual abuse are a parent or someone in a caretaking role (Finkelhor, 1994).

Behaviors that are adaptive – for example, dissociation that removes one from traumatic events, substance use that suppresses those events, hypervigilance that is protective, or self-imposed isolation that avoids betrayal of trust – eventually exacerbate the troubles in trauma's wake. Adaptations that began as coping mechanisms end up as problems, some of which amplify the likelihood that individuals will experience additional trauma.

Impact as Cumulative, Additive, and Summative

Recent studies support the conclusion that the impact of trauma is not only **cumulative** – the more times a traumatic event is experienced the greater the impact – but also **additive**: exposure to additional *different* types of trauma is correlated with greater impact (Finkelhor, Ormrod, Turner, & Hamby, 2005; Turner & Lloyd, 1995; Turner et al., 2006). To this we would add that the impact of trauma is **summative**: the combination of ***event(s) plus impact*** is what individuals carry forward through time inscribed in memory, sense of self, and behavior.[iv]

The most compelling evidence of the cumulative nature of trauma's impact – and, we would argue, also of its summative nature – is to be found in the Adverse Childhood Experiences or ACE Study being conducted collaboratively by Kaiser Permanente and the Centers for Disease Control. Just more than half of a sample of over 17000 "middle-class" adults in Kaiser's HMO reported experiencing one or more of eight adverse childhood experiences (recurrent physical abuse, recurrent emotional abuse, sexual abuse, incarceration, alcohol or drug use problems, or mental health issues of a household member, domestic violence in the household, death of a parent), one in four reported two categories, and one in sixteen reported four categories. The study found a dose-response relationship between number of different childhood adverse events experienced and later life health consequences, including not only addiction and mental health issues but also "organic disease" (Felitti, 2002, p. 1; see also Felitti et al., 1998). Simply put, as the types of adverse events experienced increased – the dose – so also the adverse health effects increased – the response. "For example, a male child with an ACE Score of 6 has a 4,600% increase in the likelihood of later becoming an IV drug user when compared to a male child with an ACE Score of 0" (Felitti, 2002, p. 4).

Impact as Intergenerational and Transferable

The findings of the ACE Study underscore the already well-known fact that trauma reverberates from one generation to the next. Experiencing interpersonal abuse is risk-laden, as it heightens an individual's chances of experiencing problems with substances, mental health issues, homelessness, additional interpersonal violence, justice system involvement, and STIs, including HIV/AIDS. Any of these life issues, which are both precipitated and compounded by the disconnection and distrust that spring from trauma's violation of self and safety, can make the always difficult job of parenting that much more difficult. Witnessing parental substance abuse, the behavioral manifestations of parental mental health problems, or domestic violence puts children at risk for multiple life issues. For example, a recent review of literature on the impact of parents' mental health on their children's substance abuse, observes that "the problems associated with parental alcoholism are not significantly different from those related to parental mental illness, death, physical violence, or other severe family situations" and include "elevated risk of later depression and substance use" (Mowbray & Oyserman, 2003, p. 463-464, 472).

The intergenerational impact can also go in the opposite direction, from child to parent. A study of reactions to the 1993 World Trade Center bombing among children who were present in the building at the time and their parents who were not found stress-related symptoms, including PTSD symptoms, among the parents and concluded that "parents' long-term reactions were strongly influenced by their children's distress" (Koplewicz et al., 2002, p. 84).

Trauma's intergenerational impact is only one manifestation of a more general transferability, captured in a variety of terms, including "secondary traumatic stress reaction" (Figley, 1983, p. 12), "secondary traumatic stress" (e.g., Jenkins & Baird, 2002), or simply "secondary trauma" (e.g., Hesse, 2002); "vicarious traumatization" (McCann & Pearlman, 1990) or simply "vicarious trauma" (e.g., Schauben & Frazier, 1995); and "indirect trauma" (Clark & Gioro, 1998). Each of these terms denotes the impact of trauma not experienced directly but, rather, through contact with, including caring for, someone who has directly experienced trauma or crime victimization or even through hearing about a traumatic event such as a homicide (Lipschitz, Rasmusson, Anyan, Cromwell, & Southwick, 2000). Vicarious trauma, which may result from singular, cumulative, or additive contact, is a concern for members of the caring professions such as counselors and social workers. It is also a concern for first responders as well as long-term responders in disasters.

Trauma, Crimes, and Criminal Justice

Many traumatic events experienced in childhood, adolescence, and adulthood are criminal acts of interpersonal violence, but many, likely most, go unreported to the police; yet experiencing interpersonal violence puts individuals at risk of involvement with the criminal justice system later in life (see *Criminal Justice Systems Issues and Response in Times of Disaster* resource paper). Indeed, if our shelter system can be seen

as warehousing for individuals who are homeless (Hopper, 2003), then our prison and jail systems might be seen as mandated warehousing for individuals who have survived interpersonal violence. Many incarcerated women have been victims of violence (Covington, 1996; DeCou, 2002; DeCou & Van Wright, 2002; Galbraith, 1998; Holden, Rann, & Drasek, 1993; Kassenbaum, 1999; Veysey, 1998) often by a relative, foster parent, or other caregiver. In a retrospective study of 100 men incarcerated in jail, 59% reported some form of childhood sexual abuse prior to puberty (Johnson et al., 2006). What individuals who have experienced interpersonal violence (some of whom may eventually become incarcerated) and individuals who have been the victims of violent crime (some of whom may have previously experienced interpersonal violence) have in common is trauma.

Among a randomized sample of 3,897 men incarcerated in prison in six states, the mean percentage of those in 1968 with at least one prior state mental hospitalization was 7.9, with a range of 0.3 to 12.5 (see Table 2 of Steadman, Monahan, Duffee, Hartstone, & Robbins, 1984, for complete data). A comparative study conducted in a rural US state found high rates of mental health disorders among men in prison but not among men in jail, with the most prevalent (non-substance abuse) disorders diagnosed being antisocial personality (50.8%), posttraumatic stress (27.1%), and major depression (11.9%) (see Table 4 of Powell, Hold, & Fondacaro, 1997, for complete data). In a random sample of 728 men incarcerated in an urban jail, Teplin (see Table 1 of Teplin, 1994, for complete data) found current and lifetime prevalence of antisocial personality disorder of 48.40% and 49.21%, anxiety/somatoform disorder of 11.62% and 21.02%, major depressive episode of 3.42% and 5.09%, and schizophrenia of 2.98% and 3.82%, respectively. She also found the prevalence of schizophrenia and other severe affective disorders among male jail inmates to be two to three times that of men in the general population (see Tables 1-2 of Teplin, 1990, for complete data). Epidemiological studies show that a higher percentage of incarcerated women than incarcerated men have mental health issues (Veysey, 1998). Teplin, Abram, & McClelland (1996) found that 80% of a random sample of women in the Cook County jail between 1991 and 1993 had one or more psychiatric diagnoses in their lifetime, with depression and PTSD common.

Substance abuse disorders are also common among both male and female inmates. Among Teplin's (see Table 1 of Teplin, 1994, for complete data) random sample of 728 men incarcerated in an urban jail, 29.11% and 61.25% had current and lifetime prevalence, respectively, of substance abuse disorder. The vast majority of women in jails and prisons in the US have long-term substance abuse issues. A National Institute of Justice [NIJ] (1994) nationwide survey found that more than half of women test positive for illicit drugs at the time of their arrests. According to estimates by the Massachusetts Committee on Criminal Justice, 90% of women prisoners have alcohol or drug problems. In fact, "several measures show that women offenders are more likely than male offenders to use drugs, they use more serious drugs than male offenders, and they use them more frequently" (Kassebaum, 1999; see also Veysey, 1998). According to data from both the Bureau of Justice Statistics [BJS] (1992) and NIJ (1991, 1997), "women are more likely than men to be under the influence of drugs at the time of their crimes" (Kassebaum, 1999, p. 14).

Thus for many women, experiencing violence is the precursor and precipitant to their key so-called criminogenic risk, namely, substance abuse. Research suggests that "abuse (sexual, emotional, physical) might be the most significant underlying cause of high-risk behaviors leading to delinquency in girls" (Prescott, 1997, p. 3). Indeed, feminist analyses of pathways to crime identify childhood trauma and subsequent substance abuse as centrally linked to offending among women (Bloom & Covington, 1998; Owen, 1998). Based on national and California data, Owen and Bloom (1995) report that 80% of women prisoners have children. The incarceration of a parent is one of the adverse events found in the ACE Study to have long-term health consequences (Felitti, 2002; Felitti et al., 1998), so a woman's incarceration may be traumatic to her children, providing us with yet another permutation on the intergenerational reach of trauma.

Trauma versus Victimization and Problematizing "re"

The word 'victim' is often used with reference to being the victim of a violent crime (e.g., Macmillan, 2001); sometimes, however, this word is used to describe someone who has experienced sexual or other interpersonal trauma (e.g., Raghaven, Bogart, Elliott, Vestal, & Schuster, 2004). Many survivors of trauma reject this appellation because it implies passivity on their part and because it suggests that the event defines the person, giving power to the perpetrator. In SAMHSA's Women, Co-Occurring Disorders and Violence Study, women who met the study eligibility criteria, that is, had experienced trauma and had been given diagnoses of mental illness and substance abuse, who partnered in the design and implementation of the study and the analysis of its findings chose to call themselves **C**onsumers/**S**urvivors/**R**ecovering persons or C/S/Rs for short.[v]

Sometimes the term "revictimization" rather than "retraumatization" is used to designate re-experiencing interpersonal trauma again, especially later in life after an earlier trauma (e.g., Dutton et al., 2005; Russell, 1986). For the purposes of SAMHSA's "After the Crisis: Healing from Trauma after Disasters" initiative, "revictimization" is used with reference to justice-involved individuals against whom a crime has been perpetrated, who then suffer in association with a disaster in which court cases may be on hold and evidence lost (see *Victims of Violence in Times of Disaster or Emergency* resource paper).

The term "retraumatization," on the other hand, refers to experiencing another traumatic event and the impact of that experience. Obviously, given what has just been reported about the facts that traumatic events are often criminal, that individuals who have experienced trauma often become involved in criminalized activities such as substance use and may themselves become incarcerated, and that both using substances and having emotional problems increase the chances of being the victim of violent crime, the line between "revictimization" and "retraumatization" begins to blur.

With both terms, the prefix 're' demands attention. Derived from Latin, it means "again." With respect to trauma, by attaching the meaning of 'again' only to trauma that happens at an interval after an initial trauma erases the possible repeated nature and duration of the later trauma and its impact, and also erases the repeated nature and duration of much initial trauma and its impact. We know that both child abuse and domestic violence are more often repetitive and prolonged than singular and short. "Child victims are usually victimized repeatedly over time," conclude Turner et al. (2006, p. 14, 16) based on recent studies, including theirs on the "experiences of a nationally representative sample of 2030 children aged 2-17." So, rather than as trauma once again, ***re***traumatization should be understood as trauma yet again, with this 'yet again' likely to be again and again, as in repeated domestic violence, that follows previous trauma, that was itself likely to have been not once but again and again and yet again, as in repeated childhood sexual and/or physical abuse.

Some researchers have argued that "personality traits" may account for re-exposure to trauma, suggesting, for example, that "personality traits related to impulse control may be associated with increased probability of encountering a traumatic event" and that "[b]orderline personality may represent the same risk factor among women that antisocial personality does among men" (Lauterbach & Vrana, 2001, p. 30). Given that experiencing trauma is a known risk factor for eventually being designated with the diagnosis of antisocial personality disorder or borderline personality disorder, this line of "research" seems to constitute blaming the victim of the very worst kind, namely, blaming the victim in the name of science and bolstered by so-called scientific findings.

Just as trauma can be experienced secondarily, vicariously, or indirectly, so too can retraumatization: secondary retraumatization, vicarious retraumatization, or indirect retraumatization. Individuals who have themselves already experienced a trauma can be retraumatized through contact with, including caring for, someone who has experienced such an event (which for the person directly experiencing it may be either trauma or retraumatization). Thus, retraumatization, like trauma, is transferable.

Retraumatization and Disaster

Numerous studies suggest that experiencing trauma heightens vulnerability to other traumatic events. Experiencing the repetition of a traumatic event – another rape, another molestation, another beating – is retraumatization. The term has also been used in the scholarly literature to denote delayed onset or reactivated symptoms related to something traumatic experienced in the past, for example, "combat-related psychiatric symptoms emerging in previously asymptomatic war veterans, even 50 years after combat" (Sadavoy, 1997, p. 292).[vi] Based on a case-control study conducted in Israel during the First Gulf War of elderly Holocaust survivors and other elderly who had no direct experience of the Holocaust, Sadavoy (1997, p. 292) concludes that reductions in coping mechanisms with aging may elevate "vulnerability to retraumatization." The Detroit Area Survey of Trauma found that having previously experienced a traumatic event was associated with higher likelihood of developing PTSD when exposed to another traumatic event (Breslau, Chilcoat, Kessler, & Davis, 1999).

In addition to all the traumatic events already discussed, other events can be retraumatizing. Events or circumstances that echo the violation and lack of control of an earlier trauma can be retraumatizing. So, for example, we know that for many individuals with histories of trauma being institutionalized, whether in a hospital, jail, or prison, can be traumatic (Jennings, 1994). Physical restraints and chemical restraints, as well as strip searches and other forms of coerced interventions, tangibly evoke previous violation of person and control (Allen, 2006; Huckshorn, 2005; Smith, 1995). Incarcerated women, many, if not most, of whom have histories of physical and/or sexual abuse, "are particularly sensitive to coercive situations" (Veysey, DeCou, & Prescott, 1998, p. 51). The same could be said of incarcerated men. As Veysey et al (1998, p. 51) observe, "many of the standard and routine procedures used in jails to process individuals, provide security, and meet medical standards of care may unintentionally retraumatize women with abuse histories." Again, the same could be said of incarcerated men. Incarcerated women and men need to be supervised and sanctioned in trauma-informed ways that recognize their needs while maintaining security (DeCou 2002; DeCou & Van Wright, 2002; see *Criminal Justice Systems Issues and Response in Times of Disaster* resource paper).

Disasters, whether natural, man-made, or a combination of the two, can be traumatizing to anyone and, to those many individuals who have already experienced trauma, retraumatizing. As Farmer (1992, p. 9) has shown with respect to the AIDS pandemic, disasters reveal the "fault lines" of society. In destroying lives, buildings, and communities, Katrina laid bare inequalities – along axes of race/ethnicity, geography, health, wealth, and opportunity – that in the US today are both enduring and enlarging. One fault line consistently revealed in disasters is gender inequality. Enarson (2004) has meticulously detailed and documented with data from around the globe, including the US, that "gender matters" from initial warnings, which women may be less likely to receive, to the aftermath of disaster, when girls and women face increased risk of sexual and domestic violence, expanded caregiving responsibilities, and reduced access to relief vis-à-vis boys and men.

We would argue that disasters and their aftermaths join conflict and political repression as "continuing trauma" (Straker & Moosa, 1994); in such contexts, helpers such as first responders, medical personnel, and counselors, who may or may not themselves have histories of trauma, are at risk of traumatization or retraumatization. Indeed, during disasters, traumatization-at-a-distance – or retraumatization-at-a-distance for those with trauma histories – is possible as images of death and destruction are displayed repeatedly on TV screens across the nation, echoing the repetition that so often characterizes the direct experience of traumatic events. Based on PTSD-like symptomology among a randomly selected sample of children in New Hampshire and California after the 1986 explosion of the space shuttle Challenger in far-away Florida, Terr et al. (1999, p. 1542) propose "distant trauma" as a new category within the "trauma spectrum."

Social scientific studies have learned what those who have lived through disasters already know: there are two dimensions of experiencing a disaster, both of which can be traumatic. The first is the disaster itself, which, as with Katrina, includes danger, destruction, and death. Anyone who survives the disaster event is then left in a changed world, one in which destruction of the physical environment, disruption and even rupture of the social environment of family and neighborhood, and often displacement destabilize or even destroy one's sense of self, safety, and normalcy.

In a moving book about a flood in Appalachia, Erikson (1976) draws on the words of survivors to discover the disconnection and dislocation they felt both immediately and long after the waters had receded. Individuals withdrew from family members, friends, and neighbors, numbed and disoriented; "even the closest family groups had trouble maintaining their old intimacy in the wake of the flood" (Erikson, 1976, p. 145). Familiar places and rhythms ground human beings. In Buffalo Creek, West Virginia these were wiped away by a wall of water.

Without familiar places and rhythms even those who have not previously experienced trauma have difficulty sustaining internal equilibrium and external relationships. In the wake of disaster, domestic violence, child neglect and maltreatment, drug and alcohol use, suicide, and divorce ***all*** increase (Enarson 1999, 2000, 2004; Erikson 1976). One of the most damaging decisions in the aftermath of the Buffalo Creek disaster was that the federal Department of Housing and Urban Development allocated trailers in a makeshift camp without making any "effort to group people according to old neighborhood patterns" (Erikson, 1976, p. 148), patterns that might have immediately helped survivors to recapture some normalcy in an "abnormal world." On a SAMHSA-sponsored conference call about the "After the Crisis" initiative held on December 14, 2005, this phrase was used by a participant from the Gulf Coast to describe the situation in the aftermath of the disastrous hurricanes. It is important to note that for those who have experienced trauma, the world is ever after abnormal rather than "normal" in that they can never return to a world in which the traumatic event did not happen, in which their self was not violated, and in which their trust in other people and the order in the world was not undercut. This is true for those who have suffered the trauma of interpersonal violence, as well as for those who have suffered violent crime (personal communication, H. West, GAINS Conference, Boston, MA, April 6, 2006).

After the immediate danger of a disaster is over, aid seems to focus on meeting the most basic needs in Maslow's hierarchy of needs, namely, food, water, and shelter. While these are obviously crucial, disaster planning in the US might take a lesson from practitioners in the international arena providing relief to refugees. When refugees fleeing whatever horror engulfed their homes arrive at the site of a refugee camp, relief workers always immediately ask about family and other social connections so that the disoriented and distressed refugees can be settled close to those with whom they have bonds of kinship and community. Re-establishing connections may be especially important for those who are not only traumatized but retraumatized, suffering multiply from the disconnection that is perhaps trauma's deepest damage. Everyone feels powerless in the face of the destructive might of nature, as in Katrina, or of man, as in the

Oklahoma City Bombing and 9/11. But feeling disempowered can be especially destabilizing and disturbing to someone who may already feel disempowered from previous trauma.

Two additional points are important. First, not everyone, trauma history or no, reacts the same way to traumatic experiences, including disaster. Some freeze, withdraw, or act out. But others reach out, as in peer support efforts after the Oklahoma Bombing, 9/11, and Hurricanes Katrina and Rita (see *From Relief to Recovery: Peer Support by Consumers Relieves the Traumas of Disasters and Recovery from Mental Illness* resource paper).

Second, given the prevalence of trauma, it is important for ***all*** of us to be trauma-informed. Given that prevalence and given that many who have previously experienced trauma have not revealed this, whether from isolation, incapacity, lack of conscious memory, fear of not being believed, as may well have happened earlier, or aversion to the stigma attached to those who experience trauma, most especially sexual trauma, it is also important for each of us to ***presuppose trauma***, that is, to adopt a ***universal presumption of trauma***, recognizing that it may be part of the life of any individual in times of calm or in times of disaster (Reed, manuscript in preparation). In a disaster, this is true of first responders, medical and other clinical practitioners, government planners and policymakers, representatives of agencies both governmental and non-governmental who provide aid, and each of us as citizens. All of us should adopt a universal presumption of trauma with which we take on an understanding of and a sensitivity to the suffering of trauma that is part of the lives of too many Americans, indeed of too many people everywhere. This is not only good human practice, it is good public health practice. It is good public health practice not only when disaster strikes but ***all day, every day***, because daily life's ordinariness masks ongoing interpersonal violence that continually constitutes trauma's terrible prevalence.

All parenting individuals need support with parenting in the wake of disaster. For individuals who have experienced childhood abuse, seeing their own children hurt or disoriented by disaster may be particularly retraumatizing. Feeling powerless to protect them may in and of itself be retraumatizing. To decrease the intergenerational dimensions of trauma's damage, special attention must therefore be paid in the immediate and longer term aftermath of disaster to supports that assist retraumatized parents to care for their children at a time when the children themselves have unexpected and intensified needs.

At the 2006 National GAINS Center Conference on "System Transformation at the Interface of the Criminal Justice and Mental Health System", a member of the audience at the panel on the "National Institute of Mental Health, Small Business Innovative Research Adult Cross-Training (AXT) Curriculum Project" described parenting issues of incarcerated individuals as "ancillary," only requiring attention during reentry planning prior to release (April 6, 2006, Boston, MA). Norma Finkelstein (Finkelstein 1994; Moore & Finkelstein, 2001), a pioneer in providing substance abuse services for pregnant and parenting women, teaches that addressing parenting issues is

crucial to recovery. In the Women, Co-Occurring Disorders, and Violence Study sample, mothers who were separated from their minor children had more extensive trauma histories than those who were not (Nicholson et al., in press). Based on two panels on parenting organized by Consumer/Survivor/Recovering women working on the Women, Co-Occurring Disorders, and Violence Study, we would argue that parenting issues are never merely ancillary to the healing and recovery of individuals with trauma histories. Just as social needs should never be put in abeyance, so parenting needs should never be put on hold, whether during incarceration, treatment, or peer support. Whether they self-consciously chose never to parent because of their own trauma histories, whether they lost custody of their children due to substance use or other life issues, or whether they regretted the way they parented because of their own issues, the brave and generous women who shared their stories during these two panels reported that parenting remained a permanent and painful part of their lives, a part that for many became joyful after they entered recovery and were able to nurture themselves and others, including their children; regained custody of their children; or had a second chance at parenting with their grandchildren.

Scholarly literature and personal stories of those who have experienced trauma teach us that often what is needed for healing and recovery is just one individual who is non-judgmental and caring (Fisher, 1999; Royster, 2006; Saakvitne, 2000). During and after a disaster, whatever can be done to reestablish human connections can be especially vital for those who have previously experienced trauma, those who are already struggling against the disconnection that is, as Judith Herman taught us, trauma's legacy. Whatever can be done that permits survivors of disaster to participate in their healing and recovery and that of their communities would counteract both disconnection and disempowerment, with community and peer support key vehicles for such engagement (see *From Relief to Recovery: Peer Support by Consumers Relieves the Traumas of Disasters and Recovery from Mental Illness* resource paper).

Recommendations for Trauma-Informed and Retraumatization-Informed Disaster Preparedness and Response

At the individual, family, local, state, and national levels, both preparedness for and response to disaster must be designed and implemented with an awareness of trauma and retraumatization. Thus, preparedness and response must be both trauma-informed and retraumatization-informed. The "After the Crisis: Healing from Trauma after Disasters" Expert Panel, sponsored by the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA), makes the following recommendations to infuse knowledge of trauma and retraumatization into preparing for and responding to disasters. These recommendations underpin at the same time that they complement the recommendations contained in the working papers on peer support services, victims of violence, and criminal justice issues in time of disaster.

1) **Trauma-Informed Public Health Education** to provide knowledge broadly to the citizenry about the prevalence of trauma, the possibility of retraumatization, the impact of both, including disconnection, substance use and abuse, interpersonal violence, risky sexual behavior, and involvement with the justice system; about disaster as trauma and retraumatization; and about vicarious (re)traumatization and (re)traumatization-at-a-distance.
    a) Everyone – parents; teachers and school administrators; health workers; justice and criminal justice professionals from police, prison staff, and parole officers to judges; first responders; social workers; policy-makers and government officials – must be educated about trauma and retraumatization. Such education should be incorporated into the curricula of public schools; schools for educational professionals and for justice and criminal justice professionals; schools of social work; nursing, medicine, and other schools for health and behavioral health professionals and into the training for emergency medical technicians, police, fire fighters, and other first responders.
2) **Universal Presumption of Trauma** is demanded by the prevalence of trauma and retraumatization and by the vulnerability and lack of connection felt by those who have experienced either.
    a) Each of us should adopt a universal presumption of trauma, recognizing that it could be part of the life experiences of anyone with whom we interact.
    b) Screening for interpersonal violence and other stressful events should be routine in primary care, emergency medicine, school guidance and counseling, and behavioral health services for substance abuse and mental health.
3) **Silence about Trauma = Support for Trauma Stigma**.[vii] Acknowledgment of trauma's prevalence and impact will contribute to banishing the stigma attached to experiencing trauma and the associated silence that prevents individuals who have experienced trauma from seeking assistance and protects those who perpetrate interpersonal violence, too often shielding them from punishment and permitting them to repeat the violation.
4) **Trauma-Informed, Retraumatization-Informed, Family-Focused, Gender-Specific, and Community-Conscious Disaster Response, Both Short-Term and Long-Term**
    a) For those who experience disaster:
        i) Planning in preparation for disaster must be based on the presumption of trauma.
        ii) Responses to those who experience disasters must be based on the presumption of trauma.
        iii) To the extent possible meeting emergency needs for safety, food, water, and shelter should treat individuals not in isolation but as members of families and communities and should attempt to recreate the familiar rhythms, routines, and spatial arrangements in which our sense of ourselves is grounded.
        iv) Longer term response must intensify the focus on reestablishing rhythms of life and reconnecting ties of kinship and community.
        v) Attention should be paid to the gendered dimensions of disaster's impact to minimize inequality in access to care and resources.
        vi) Children must be prioritized and parenting supported.

vii) Individuals with lived experience of trauma, disaster, substance abuse, and mental illness must play a key role in preparedness planning and in disaster response in both the short-term and the long-term (see *From Relief to Recovery: Peer Support by Consumers Relieves the Traumas of Disasters and Recovery from Mental Illness* resource paper).

b) For those who respond to disaster:
   i) Recognizing that responders, both first and long-term as well as both paid professionals and volunteers, feel the direct and/or indirect effects of trauma and, in some cases, retraumatization; supports must be put in place to normalize rather than pathologize reactions and cushion their impact.
   ii) Supports must be put in place for families of responders to minimize the ripple effects of trauma and to lessen the stress on responders whose demanding work obligations not only take their attention away from caring for their own families but also reduce their emotional resources to provide such care.
   iii) Special supports should be put in place for children of responders.
   iv) Individuals who have themselves experienced trauma have a vital role to play in supporting responders (see Peer Support Models working paper).

Trauma-informed preparedness planning, response to disaster victims, and support for responders in both the immediate aftermath of disaster and over the longer term promise to minimize damaging reverberations in myriad lives and across generations by fostering resiliency and recovery.

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Endnotes

[i] The published literature on PTSD is contentious. In an effort to banish such contentiousness, we would like to point out that to argue, as Young (1995) and Summerfield (2001), among others, have done, that PTSD as an historically (or politically) constructed classification should not be read as denial that traumatic events occur or that such events have an impact on individuals who suffer them. Summerfield's (2001, p. 95) summary points that "[a] psychiatric diagnosis is not necessarily a disease" and that "[d]istress or suffering is not psychopathology" are in keeping with what we present in this working paper. The literature on PTSD is also complex, as evidenced by Judith Herman's introduction of "complex PTSD" (Herman, 1992a, p. 377) for inclusion in the DSM-IV-TR under the category of "Disorders of Extreme Stress Not Otherwise Specified (DESNOS)." Though not officially included in the DSM-IV-TR, complex PTSD is used by Herman and others to designate PTSD "in survivors of prolonged, repeated trauma." Whereas some experts have applauded the extension of the category of PTSD as a means of "capturing the psychological responses to trauma" (Ide & Paez, 2000, p. 43; see also Zlotnick et al., 1996), others have questioned whether its "sheer breadth . . . limits its descriptive usefulness" (Allen, Huntoon, & Evans, 1999), including those who have found "ample confirmation [for Herman's formulation of complex PTSD] in personality assessment of women in inpatient treatment for trauma-related disorders" (Allen et al., 1998). An instrument to measure complex PTSD or DESNOS has been developed called the Structured Interview for Disorders of Extreme Stress (SIDES), and the World Health Organization [WHO] has accepted personality changes due to extreme stress in its international classification system (de Jong, Komproe, Spinazzola, van der Kolk & Ommeren, 2005). A recent test of the cross-cultural validity of SIDES failed to demonstrate construct equivalence in diverse settings (de Jong et al., 2005).

[ii] Given the association between trauma and risk of HIV/AIDS through either sexual contact or intravenous drug use, the Centers for Disease Control might well add questions about interpersonal violence to the questions that clinicians are required to ask that generate the information on which the national data on incidence of HIV infection and modes of transmission are based. In addition, the American Red Cross, which serves as our nation's unofficial blood bank, might do well to add the same questions to its screening questionnaire for prospective donors. Besides collecting valuable information about HIV risk, the asking of such questions would contribute to the creation of a trauma-informed health system in the US, would aid in dispelling stigma associated with experiencing interpersonal violence, and would help reduce the likelihood that someone will never be asked about their trauma history. In SAMHSA's Women, Co-Occurring Disorders, and Violence Study, some women reported that the baseline interview, which included an extensive instrument on life stressors from natural disasters to interpersonal violence, was the first time they had been asked about physical and sexual abuse. This despite the fact that to meet study eligibility criteria each of these women had to have accessed services for mental health and/or substance use issues at least twice prior to entry into the service system that led to study recruitment.

[iii]The physical, physiological, and biochemical impact of torture has also been studied. For example, Moreno and Grodin (2002) provide a "clinical review" of published literature about "Torture and Its Neurological Sequelae," including brain injury, headaches and vertigo. Hull (2002, p. 102) reviews "structural and functional studies of the brain and also studies combining both modalities" to assess what is known about neurobiological changes in brains of individuals with PTSD. In a review on the study of PTSD, McNally (2003, p. 239) reports that the finding that "prolonged glucocorticoid exposure produces hippocampal atrophy, at least in rats and monkeys" has led researchers to the hypothesis that among humans "extreme stress might have damaged the hippocampus of trauma survivors." After surveying the published literature on this topic, McNally (2003, p. 240) notes that, despite some studies that are consistent with the hypothesis, "other factors strongly argue against this interpretation." He concludes that a "landmark" MRI case-control twin study by Gilbertson et al., published in 2002, in which one twin served in Vietnam and developed PTSD and the other did not "may have decisively refuted the atrophy hypothesis" (McNally, 2003, p. 240). Instead Gibertson and colleagues claim that "small hippocampi may constitute a preexisting vulnerability factor for PTSD among trauma-exposed" (McNally, 2003, p. 241). A major conference on "Posttraumatic Stress Disorder: Biological, Clinical, and Cultural Approaches to Trauma's Effects" sponsored by The Foundation for Psychocultural Research and The University of California, Los Angeles, December 12-15, 2002, focused on "neurobiological, psychiatric, anthropological, and historical levels of analysis" (Lemelson & Tobin, 2002, p. 4). We suspect that what social medicine and epidemiology call the "cause of causes" in the case of differential resiliency and vulnerability across individuals not only to PTSD but to the impact of trauma broadly construed likely resides in social factors. Searching for the sources of response and resiliency in biophysiology alone seems both simplistic and reductionist.

[iv]Thanks to Richard J. Parmentier for help clarifying the concept of "summative trauma" and for pointing out its similarity to Husserl's discussion of memory and time.

[v]The term 'consumer/survivor' is used by Fisher (1999). Ruta Mazelis (2003) prefers the phrase "persons with lived experience." This phrase, in which the experience is captured in a description rather than a noun, does not equate the person with the experience. It is that equation that has been criticized, for example, by persons with disabilities in advocating that the label "the disabled" not be used. Zola (1991, p. 10-11), a medical sociologist, has written eloquently on the subtle shades of meaning implied in use of nouns versus verbs, including active versus passive verbs, and of nouns versus adjectives with reference to persons, like himself, who use wheelchairs.

[vi] The debate over the existence and accuracy of recovered memory, which has been called "the most contentious issue in the field of traumatic stress" (McNally, 2003, p. 241), is beyond the scope of this working paper. While not denying the possibility that suggestion, whether by counselors or criminal investigators, might contribute to some "recovered memories," there is nonetheless evidence that some people do suppress memories of traumatic events and recollect them later. Women who participated in SAMSHA's Women, Co-Occurring Disorders, and Violence Study completed an

extensive questionnaire about stressful life events, at the end of which they were each asked about any other upsetting or stressful events not included and what that event was. Two of the responses suggest recovery or piecing together of memories of past sexual trauma.

[vii]This equation is inspired by "Silence=Death", the slogan coined by AIDS activists in New York City during the early years of the pandemic.

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