TRAUMA MATTERS

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The Bond That Harms:

The Impact of Trauma Bonding on Human Trafficking Victims

Human trafficking is the second most profitable illegal crime in the world (Baldas, 2012). The sale of humans continues in the 21st century at an alarming rate, including right here in Connecticut. Globally, an estimated 27 million adults and 13 million children are sold for sex and labor (Lenhnardt, 2016). The U.S. State Department stated, "Human trafficking is one of the greatest human rights challenges of this century, both in the United States and around the world" (Skinner, 2008).

What is human trafficking? The Trafficking Victims Protection Act of 2000 defines severe forms of trafficking in person as:

- **Sex Trafficking:** the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion or in which the person induced to perform such act has not obtained 18 years of age. The term "commercial sex act" means any sex act on account of which anything of value is given to or received by any person.
- **Labor Trafficking:** the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery (U.S. Department of State, 2016).

The trafficking of individuals for the purpose of sex or labor is often believed to be an international issue, not a domestic crisis. The reality is that human trafficking does not discriminate based on race, socioeconomic status, age, gender, or geographic location. Thousands of human trafficking cases occur here in the United States. The National Human Trafficking Resource Center Hotline received reports of 25,696 cases of human trafficking from 2007 to 2015. The majority of these cases were sex trafficking cases (Polaris Project, 2016).

If human trafficking is not just a global issue but a national issue, can it also be a local issue? The answer is yes. Human trafficking exists not just in Connecticut's major cities but in our suburbs as well. The State of Connecticut Department of Children and Families (DCF) has increasingly sharpened its focus on the growing issue of domestic minor sex trafficking (DMST) afflicting children across the state. From 2008 to 2016, 633 children have been referred to DCF as high-risk or confirmed victims of DMST. Victims range from the age of 2 to 18 years old, both boys and girls, and are of various racial groups and socioeconomic statuses. Every year, the number of referrals to DCF increases. In 2015, a total of 133 referrals were called in to DCF, and in 2016, the number of referrals increased to 201 (Department of Children and Families, 2016). Too many of our children are being exploited and as a result are experiencing psychological and physical trauma at an early age.

Many human trafficking victims experience repeated exposure to traumatic events as a result of trauma bonding. Dutton and Painter (1993) defined trauma bonding as the situation in which "powerful emotional attachments are seen to develop from two specific features of abusive relationships: power imbalances and

intermittent good-bad treatment". Sex traffickers use various strategies to attain control and obedience from their victims, which results in their victims' dependence on them. These strategies include "subjecting their victims to starvation, rape, gang rape, physical abuse, beating, confinement, threats of violence toward the victim and victim's family, forced drug use, and shame" (Skinner, 2008).

Erin Williamson, director of Survivor Care at Love 146, a nonprofit organization that works with DMST youth, stated, "We can have youth recognize the horrible exploitation and even physical abuse they sustained at the hands of their trafficker, and in the same breath tell us that they still 'love' them". She continues, "Traffickers spend a lot of time up front grooming these youth…They convince these youths that they are the only ones who truly care, that they can protect them and care for them". This level of manipulation distorts the youths' perception of victimization. The impact of trauma bonding is that it prolongs the exploitation of trafficked youth, leaving many victims traumatized and in need of healing.

Angela Ritter, a survivor of trafficking notes, "Not everybody gets a chance to be a survivor, and there are girls out there right now that don't even know that they're victims … but maybe, just maybe, they'll see one of us and they'll hear one of us and they'll know that there is help, there is hope and there is a way out."

Repeated exposure to sexual exploitation has a tremendous impact on the physical and psychological health of a human trafficking victim. An estimated 30,000 victims of sex trafficking die around the world each year from abuse, disease, torture, and neglect (Lenhnardt, 2016). Those who survive their exploitation report having various symptoms, such as trauma bonding and attachment issues, eating disorders, depression, anxiety, suicidality, self-injurious behavior, substance abuse, and medical issues (Swaroop, Hopper, Musicare, & Spinazzola, 2016).

The goal of DCF's Human Anti-trafficking Response Team (HART) is to develop a comprehensive system that will be a bridge from trauma and turmoil to healing and recovery for trafficking victims. In collaboration with The Village for Families & Children, The Connecticut Children's Alliance, the International Institute of Connecticut, Love 146, The Underground, the Governor's Task Force on Justice for Abused Children, the U.S. State's Attorney's Office, the Federal Bureau of Investigation, law enforcement, the Connecticut State's Attorney's Office, and many other providers across the state, DCF is poised to combat human trafficking in Connecticut and end the sale of our children.

DCF's efforts to end human trafficking falls within three categories: Identification and Response, Awareness and Education, and Restoration and Recovery. HARTs are in each DCF area office. Experienced HART liaisons lead these interdisciplinary teams that include the child's treatment team, specialized providers, and legal representation if indicated. The HART liaison works with the local Multi-Disciplinary Team (MDT), ensuring the children and families receive all the resources needed to get the appropriate medical and mental health services they are entitled to as victims, as well as maximizing prosecutions (Department of Children and Families, 2016).

The eradication of human trafficking and the harm it creates requires a collective response and awareness that recovery is attainable. We aim to live in a world free from human trafficking. Former president Barack Obama said it best when he stated, "Today, we continue the long journey toward an America and a world where liberty and equality are not reserved for some, but extended to all. Across the globe, including right here at home, millions of men, women, and children are victims of human trafficking and modern-day slavery. We remain committed to abolishing slavery in all its forms and draw strength from the courage and resolve of generations past."

Submitted by Yvette Young, LPC.
For a complete list of references please go to this issue at:
http://www.womensconsortium.org/trauma-matters

Trauma in Women Experiencing Homelessness

She lost everything and now lives place to place, couch surfing, hoping to find room in a shelter or check in to the local emergency room. When she can't, she stays on the streets. Her mind races through the traumatic possibilities a new day and night may bring: "Where will I sleep?" "How will I get food?" "Will I be raped tonight?" "Will I survive the cold?" These thoughts and events wreak havoc on a woman's mental, emotional, spiritual, and physical health. Homelessness does not discriminate by age, race, gender, or ethnicity. For women in particular, though, homelessness is a growing problem, and the services that are available to them are often scarce.

We often attribute homelessness to poverty, substance abuse, and mental illness. However, domestic violence is actually the leading cause of women's homelessness. According to the National Law Center on Homelessness and Poverty Fact Sheet (2012), "Domestic violence was the most common reason women gave for their homelessness in 2012." They continued, "…28 percent of cities cited domestic violence as a leading cause of homelessness" and "92% of homeless mothers reported experiencing physical or sexual assault." Women often experience abuse in a domestic violence situation multiple times before getting help. Furthermore, because many women are financially and emotionally dependent on their abuser, they remain in a cycle of abuse and hospitalizations before being able to leave the relationship. That initial trauma cascades throughout a woman's life, resulting in homelessness, which itself produces additional traumas.

While domestic violence dramatically increases the chances a woman will become homeless, other life events can also precede homelessness. After years of working with individuals battling the aftermath of being homeless, I have found that other common causes include the

death of a spouse, partner, or parent; a chronic physical or mental illness; and loss of employment. Many women experience a combination of these events and have a long trauma history.

The complexity of trauma and the multiple traumatic events that most women suffer prior to living on the streets are just the beginning. Often, substance use is a temporary means of escape to provide relief from the constant nightmare of living in these conditions. This lifestyle can, and often does, lead to incarceration, adding a criminal record to the mix. This continuation of trauma increases the barriers to successfully being housed once a woman is receiving services and attempting to reintegrate into the community.

For clinicians working with women experiencing homelessness, it is important to remember that recovery is rarely linear and looks different for everyone. We must celebrate the small successes. It can be extremely painful for our clients to open up to us about the events that are occurring in their lives, and building trust is key for a good working relationship. As we are often the only resource that many of our clients have, we need to be able to advocate for them and offer choices, empowering them to make tough decisions.

We as clinicians or direct care staff must tread lightly and know when to back off or press onward when working with women experiencing homelessness. Loneliness is a common thread for these women, and peers can be extremely helpful in this area by sharing their experiences, strengths, and hopes. Peer relationships create deeper connections through shared experiences and allow the client to feel safe and bonded to another person. Over the past several years, I have seen peers succeed where others have failed just by developing a unique connection that helps the person in need know she is no longer alone, and she has someone on her side.

Too often the horrors of homelessness for women begin in a place associated with safety and peace, the home. After these types of traumas occur, it takes time for women to recover and feel safe again. Flinck, Paavilainen, and Astedt-Kurki (2003) noted one woman who said, "I've had terrible times in my life, but now my life is a bit more tranquil, and I've been able to dream, and that's a good thing." As clinicians and direct care staff, it is important we understand the complex ways in which homelessness impacts women in order to begin the process of recovery. Fortunately, with proper resources and assistance, women experiencing homelessness can regain the greatest gift life has to offer: **hope**.

Submitted by Shelley Halligan, RN, MSN, MTTS
For a complete list of references, please go to this issue at:
http://www.womensconsortium.org/trauma-matters

Ask the Experts: A Conversation with Sebern Fisher

By Cheryl Kenn, LCSW

Sebern Fisher is the author of Neurofeedback in the Treatment of Developmental Trauma: Calming the Fear-Driven Brain, published by Norton in 2014.

For 15 years, she served as the clinical director of a residential program for severely disturbed adolescents. She has a private practice where she works primarily with those suffering from histories of developmental trauma, integrating neurofeedback and psychotherapy. She has written many articles and chapters on the primacy of fear in psychological disorders and on the integration of psychotherapy and neurofeedback, and she trains professionals on these topics both nationally and internationally.

1. Why or how did you enter the trauma-treatment field?

My first clinical job was as the clinical director of a residential treatment facility for severely disturbed adolescents. Although they presented with many different "diagnoses," all my patients had histories of severe abuse and neglect in early childhood. I put diagnoses in quotation marks because I agree with Bessel van der Kolk, who said that if you could strip neglect and trauma from the DSM, you would be left with a pamphlet. This is true for so many therapists working with trauma survivors.

2. What do you consider to be the most helpful stabilization skill or tool in the treatment of a trauma survivor?

I have been serving and studying in the field of trauma for 35+ years. For the last 18 years, I have integrated biofeedback to the brain—neurofeedback—into my practice of trauma-informed psychotherapy. It has become clear to me that we must help trauma survivors learn to stabilize their brains before they can truly stabilize their minds. This is what neurofeedback does.

The brain functions chemically, at the synapse, and electrically through countless oscillating networks. Emerging neuroscience is recognizing that the brain organizes itself in these electrical networks, not primarily through its chemistry, as psychopharmacology would suggest. Neurofeedback is computerized biofeedback to the electrical domain of the brain to encourage its capacity for self-organization. Trauma can leave the brain disorganized and unable to cortically control limbic

firing, or the fight-flight-freeze impulses generated primarily by the amygdala. The amygdala is devoted to our survival. It is in the nonverbal, subcortical right hemisphere—meaning we cannot talk to it. With this part of our brains calling the shots in trauma, there is an inherent limit in using talk therapy to address trauma.

3. What is something you think all trauma-focused clinicians should know?

In a nutshell, all trauma-focused therapists must understand that the underlying problem is how the developing or even mature brain has been dysregulated by trauma. People who have suffered these histories are living in fear-driven brains. They also will want to know that with computerized feedback in the context of psychotherapy, trauma survivors can learn to quiet the limbic pulses of fear, shame, and rage that overwhelm them daily. As a committed psychodynamic therapist, the first to implement DBT in a residential facility and a devoted meditator, I have come to learn that while it is not always easy, it certainly is easier to reach the mind by helping the brain to regulate than to reach the brain by working with the mind.

I believe the best training for therapists who wish to practice neurofeedback is offered by **Ed Hamlin, PhD**. His training schedule is available by contacting **Patti Lightstone** at Patti@EEGER.com. Those looking for training for their own brains can visit www.ISNR.org; www.BCIA.org; or www.EEGER.com. There are many forms of neurofeedback, and mastery of them can be gained through experience and an understanding of trauma, neglect, and attachment and compatibility. And by reading the book (*Neurofeedback in the Treatment of Developmental Trauma: Calming the Fear-Driven Brain*).

Accelerated Resolution Therapy: An Emerging Evidence-Based Therapy for Treatment of Post-Traumatic Stress Disorder and Related Comorbidities

Accelerated Resolution Therapy (ART), developed by Laney Rosenzweig in 2008, is an emerging psychotherapy that was recently recognized as a Substance Abuse and Mental Health Services Administration evidence-based therapy to treat post-traumatic stress disorder (PTSD) and other significant traumas, as well as depression (SAMHSA, 2015). ART aims to address the following four symptom clusters of PTSD according to the Diagnostic and Statistical Manual of Mental Disorders (5th edition): 1) re-experiencing memories of the traumatic event; 2) avoidance of distressing memories, thoughts, feelings, or external reminders of the event; 3) negative emotions and mood; and 4) changes in arousal and reactivity (American Psychological Association, 2013).

Compared to traditional therapies, ART has significant potential benefits for clients living with trauma and depression and their counselors, as it may work more rapidly with less treatment burden. ART is considered a brief treatment for PTSD, usually completed within one to three sessions, compared to traditional therapies requiring 3 to 6 months of treatment. Studies at the University of South Florida showed that on average, ART was completed in 3.6 sessions within a time frame of one to five sessions over 2 weeks. If a single incident caused the PTSD, then the treatment to alleviate the symptoms could often be done in one session (Kip et al., 2013).

There have been five published studies of ART, including a 2013 study in Military Medicine by the University of South Florida comparing ART for PTSD to a control condition. The results (see Figure 1) show the change found in PTSD symptom scores using the Post-Traumatic Stress Checklist – Military Version (PCL-M) questionnaire over an average of 3.7 sessions (Kip et al., 2013; Weathers, Huska, & Keane, 1991). An increase of 10 or more represents a clinically meaningful improvement in PTSD symptoms. Thus, this pilot study showed that ART provided a clinically meaningful and statistically significant improvement in PTSD symptoms over the control group.

ART targets the negative images stored in the brain and uses eye movements to "erase" them from view. Eye movements appear to open what researchers call a reconsolidation window, allowing an opportunity to switch the negative images to positive. The reconsolidation hypothesis suggests that reconsolidation is an adaptive defense and that introducing new information during this time may permanently change fear-based memories (Monfils et al., 2009). Contrary to popular belief, memories are not stored like files, in a fixed way. When we recall a memory, we are actually synthesizing new proteins in the brain to form a new conception of that memory.

Researchers do not yet know why eye movements appear to deepen and accelerate the lasting changes created during the reconsolidation window. Some speculate it could be connected to the rapid eye movement (REM) sleep state during which problem solving and filtering of information from the day take place. ART refers to the "erasing" of negative images as the Voluntary Image Replacement (VIR), which researchers believe causes increased inter-hemispheric EEG coherence in which the REM-like state enhances memory reconsolidation (Dumermuth, 1981).

Another unique component of this therapy includes the use of pictorial metaphors and metaphorical interventions, and as the saying goes, "A picture is worth a thousand words." The metaphors appear to quickly encapsulate feelings and emotions, which offers a different approach than talk therapy, which focuses on cognitions associated with the problem. During the ART intervention, the client may experience a metaphorical moment or "light bulb moment" of sudden clarity, often in less than 30 minutes. This is accomplished by resolving the metaphorical image problem, changing the image, and connecting it to the real-life solution.

ART is a directive approach that guides clients using

continuous client feedback with each step of the protocol. Due to ART's procedural nature, a client does not need to give many, or even any, problem details. The three main evidence-based components are imaginal exposure, imagery rescripting, and use of REM (Foe et al., 1999; Hackman, 2011). Therapists trained in ART at Fort Belvoir, the sister hospital of Walter Reed, were surveyed and asked which of the following therapies they liked best for their clients: Prolonged Exposure (PE), Cognitive Processing (CPT), Eye Movement Desensitization and Reprocessing, or ART. Eighty-five percent thought ART aided their clients most, and 15% thought CPT was best. When asked what they preferred most from a clinician's perspective, 100% voted for ART, as it lessens compassion fatigue, which may be due to the lack of detail clients need to provide for the therapy to work.

Although procedural, ART has many creative interventions that can be interjected into the therapy process, allowing clinicians to create their own interventions. These interventions are often metaphorical and can enhance a therapy session, giving the clients mastery over their trauma and providing tools that may be helpful reminders for changed behaviors and thoughts outside the session. Clients may laugh about a problem they never thought they could laugh about with the use of a humorous metaphor that may aid them in viewing the problem in a different, less threatening way.

Once the client rescripts the scene depicting his or her trauma, changing a negative scene to a positive scene during an ART session, changes can happen rapidly. Follow-up to integrate changed attitudes and affect is often a good idea, as family members may notice changes as the client feels and acts differently. The changes made following an ART session may feel so natural to the client that he or she may not connect these changes to the ART session. A client who had a fear of public speaking, for example, noted that when he was asked unexpectedly to speak, he did not realize until after giving the speech and reflecting back that he did not experience his normal level of anxiety. When reporting this to the developer of ART and saying he did not have an aha moment as he was asked to speak, she responded that the subsequent realization that the anxiety was gone was the aha moment.

ART's use of a Gestalt approach allows clients to go back into their childhood, taking advantage of the aforementioned reconsolidation window. The use of eye movements appears to give the clients an added sense of a dream-like reality as they rescript their trauma scenes. This empowers the clients to view the scene any way they choose, giving the adult view to an "earlier self" in their mind. They will always maintain the original factual memory, but once the images are changed, clients often report symptom relief.

There are three ART trainings for licensed mental health professionals: a basic 3-day training, a 2-day advanced training, and a 2-day enhancement training. Clinicians are able to use ART immediately after the basic training. The second training delves further into the metaphorical work. The third training gives interventions for problems such as addiction and obsessive-compulsive disorder and provides interventions that aid in externalizing the problem so that the clients can do battle with their "Little Liar," which represents the part of the clients that sabotages their changes.

There is now a national ART training and clinical research community strongly committed to further building the research evidence base for ART through a growing number of collaborations with clinical care networks and patient advocacy organizations. A major goal of ongoing research is to conduct a series of well-designed head-to-head studies of ART versus PE and CPT. The studies will examine clinical benefits and cost-effectiveness and learn more about the experience of ART from the perspective of clients and counselors as part of a series of qualitative, patient-centered studies.

Submitted by Laney Rosenzweig, ART founder, and Vickie Alston, LCSW, DCSW.
For a complete list of references, please go to this issue at:
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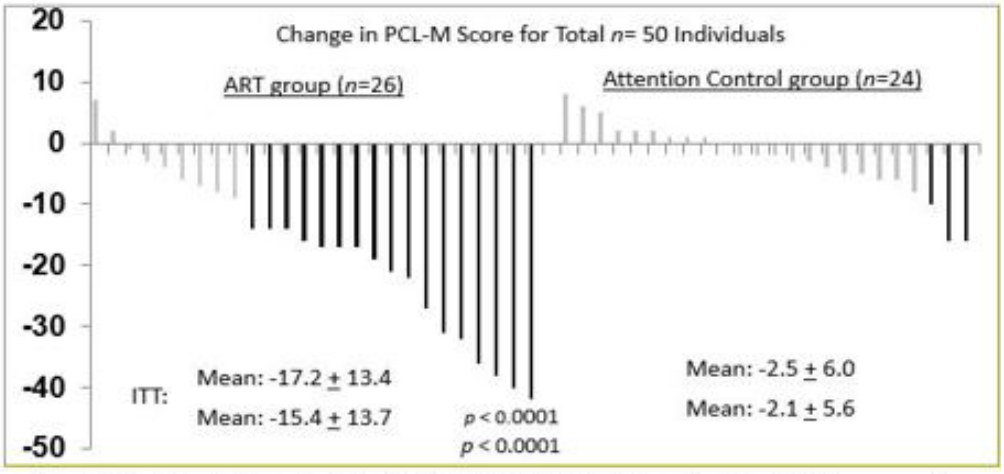


Figure 1: Results of University of South Florida (2013) pilot study evaluation of ART compared to a control condition involving N=59 military veterans with PTSD.

Featured Resource:

Take 10 Tuesdays

Take 10 Tuesdays is the new mobile self-care initiative sponsored by The Connecticut Women's Consortium (CWC). As caregivers, we often get so busy caring for others that we forget to take care of ourselves. Although rewarding, working in the behavioral health field is not always easy. Remind yourself to take 10 minutes each day to practice self-care, one of the best ways to counteract day-to-day difficulties. When you sign up for the CWC's free Take 10 Tuesdays service, you will receive a text message every first and third Tuesday of the month reminding you to take 10 minutes for yourself, along with a self-care tip, trick, or exercise. Simply text **take10** to **51555** today to sign up.

Submitted by Shannon Perkins, MSW

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Trauma in Women Experiencing Homelessness

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