Trauma Matters

Winter 2022

A quarterly publication dedicated to the dissemination of information on trauma and best-practices in trauma-informed care.

INSIDE THIS ISSUE:

A PDF version of this publication with a full list of references is available for download at: www.womensconsortium.org

Trauma-Informed Mindfulness

Practices to Promote Safety, Regulation and Resilience

by Vamsi Koneru, Ph.D.

Several years ago, I had the opportunity to work with a thoughtful patient, who we will call Emily, at a community mental health clinic. Using her life experience, she would go on to become one of my best teachers. When we met, she had experienced several forms of trauma and living in no less than 8 different placements, e.g., foster home, therapeutic youth program, by the time she was 18.

I worked with Emily on an individual basis and over several weeks we began to get to know one another. Our relationship deepened the day that she brought a football to the office. As she walked down the hallway with the football tucked under one arm, I signaled for her to throw it to me. She looked a bit puzzled—we were in a clinic after all—but nonetheless she played along. We tossed the ball back and forth before heading in for our session. A few weeks later, she had a basketball under her arm, and we played again, this time with bounces-passes in the hallway. As this playful routine continued for a few months, our trust and connection grew.

At this same time, I had become interested in mindfulness meditation, which is defined as "paying attention in a particular way: on purpose, in the present moment and non-judgmentally" (Kabat-Zinn, 1990). I thought that these practices could be beneficial for Emily, and after a brief description, I asked if she would like to try a mindfulness practice together. We began a 2-minute mindfulness of the breath practice. After we finished, Emily opened her eyes, leaned in a bit and politely, with a mischievous smile, said "I don't think I'm into this breathing shit Dr. K." In this moment, Emily taught me two fundamental lessons: 1) mindfulness of the breath is ***a*** (not ***the***) way to practice mindfulness – certainly a useful practice but not for everyone; 2) if someone is a survivor of trauma, we should consider the weight of sustained attention on internal experience. Survivors may be brought face to face with unintegrated remnants of trauma: disturbing images or feelings of terror.

By developing a trauma-informed lens to mindfulness, we can offer the transformative healing practices in an inviting manner that promotes safety, regulation, and resilience; but before moving forward, it is important to consider what trauma is, its prevalence, and its key symptoms.

Trauma is an event-or a series of events-that is highly stressful and profoundly difficult to integrate into one's life narrative. It can leave a person feeling overwhelmed, helpless and profoundly unsafe. It is a distressingly common experience: while 15% of veterans are diagnosed with post-traumatic stress disorder (PTSD), 87% of incarcerated men and 91% of incarcerated women have experienced trauma (Pettus-Davis, 2014; Wolff et al., 2014; Reichert & Bostwick, 2010). Although these numbers are alarming, and many recognize that survivors deserve support and services, some wonder how or why trauma is relevant to people in everyday life. The Adverse Childhood Experiences (ACE) Study demonstrated that trauma is shockingly commonplace in society. ACEs were identified in seven categories – psychological, physical, or sexual abuse; violence against mother; living with household members who were struggling with substance abuse, mental illness or suicidality, or were ever imprisoned (Felliti et al., 1998). In the sample of approximately 17.5 thousand individuals, 67% reported having experienced at least one ACE and nearly 13% reported experiencing 4 or more. Survivors of trauma can experience significant psychological distress marked by intrusive

memories and flashbacks, physiological hyperarousal, intense feelings of shame, self-blame and guilt, which causes people to avoid triggers or reminders of their trauma.

The data show that trauma is a highly prevalent phenomenon and emphasizes that whether mindfulness practice occurs in a classroom or boardroom, there is a likelihood that someone in the group will be struggling with traumatic stress. In nearly every context, a trauma-informed approach to mindfulness practice is critical.

But what does this actually look like? As an example, I would like us to share an experiential practice together using our hands:

1. To begin, I will invite you to make a fist with one hand. Imagine that the job of this fist is to stay closed and remain closed. And when closed, it takes care of our safety and survival.
2. Now, using your other hand, I will ask you to try to pry open your fist - and observe what happens in your body. Are there shifts in your breathing or posture? What feelings are you experiencing?

Now, let's rest a moment and open our hands.

1. For the second part of the exercise, let's use the same hand to make a fist that is representative of our safety and survival.
2. This time the other hand represents a quality of care, curiosity and respect; let's place this hand under our closed fist.
3. With the hand under the fist, allow the second hand to communicate a sense of positive regard and deep respect for the closed hand, acknowledging the deep wisdom of what it means for the fist to be closed. Now let's observe what happens in your body.

Trauma-Informed Mindfulness is about the second stage of this exercise. It is about attuning to the wisdom and needs of the survivor, not out of a sense of coddling but rather one of grounded care, embodying a deep sense of care and curiosity.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) provides a 4 "R" approach to considering Trauma-Informed Mindfulness. The 4 "Rs" are: **realizing** the prevalence of trauma, **recognizing** the symptoms of trauma, **responding** skillfully, and avoiding **re-traumatization**. The first two R's have been discussed and I would like to now turn our attention to the third R: **responding** skillfully.

In the context of our practice, there are several modifications we can make to foster a sense of invitation and promote healing. I will offer a few recommendations:

The first is to use invitational language – when beginning a practice, we might say "in the next few moments, I will invite you to close your eyes," or "let's find a spot, 1-2 feet in front of our toes, and soften our gaze on it," in comparison to "close your eyes."

Embedded in this example is also a second modification related to our eyes and gaze; mindfulness meditation is often portrayed as an eyes-closed practice, however, we want to consistently remind individuals that they remain in choice and they can have their eyes open if they find this to be supportive of their practice.

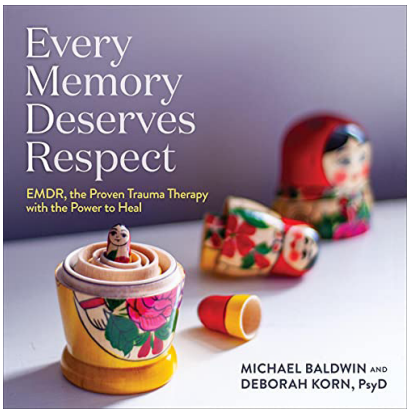
A third modification relates to the objects of attention in our practice, in other words, what we are attending to while we are practicing. Mindfulness meditation is often portrayed as synonymous with mindfulness of the breath, however, as my example with Emily highlighted, the breath is ***an*** object of attention but not ***the*** object of attention. For some survivors of trauma, paying close, sustained attention to the breath may not feel safe, thus, we may invite them to select a different object of attention in the body, e.g., the sensation of their feet on the floor, or an object of attention outside of their body, e.g., sounds in or outside of the space they are practicing. There are many other modifications that we can make and, for more examples in this area, I would refer you to the brilliant work of David Treleaven, Babette Rothschild and Sam Himelstein. Fundamentally, we want to promote a sense that the practice itself is the true teacher and that individuals are invited to collaborate and experiment to find out what is supportive to them and their recovery.

The final R, avoiding **re-traumatization**, highlights the core principle that mindfulness meditation, without a sense of trauma, can leave people feeling dysregulated and at worst re-traumatized. I believe that if we continue to deepen our understanding of these core principles and develop a trauma-informed lens, these practices can assist in fostering recovery.

Featured Resource:

Every Memory Deserves Respect: EMDR, the Proven Trauma Therapy with the Power to Heal

By Emily Aber, LCSW & Colette Anderson, LCSW



Cover of *Every Memory Deserves Respect*, which was featured in the Fall 2021 edition of Trauma Matters

Whatever your background in EMDR, from complete novice to expert; whatever your discipline, whether you are a provider or consumer, this gem of a book has something to offer. Whether you flip through and just look at the images and read the corresponding sentences, read just sections of the book, or read the book from front to back, you will learn a lot. It is co-written by the highly respected Dr. Deborah Korn, with poignant, revealing contributions by co-author Michael Baldwin, whose life was changed by EMDR therapy. This is an EMDR book that patients will read. *Every Memory Deserves Respect* and every clinician deserves to read this book. —Emily Aber, LCSW

***Every Memory Deserves Respect* is co-written by a patient undergoing EMDR therapy and a therapist who explains how and why EMDR works. Michael's journey as the patient will inspire the reader to pursue EMDR and its life-changing, evidence-based capabilities. The book comes with a trigger warning and details which pages to skip if you need to care for yourself. As professionals, *Every Memory Deserves Respect* will help you to better understand trauma history and its impact on adult relationships as well as how EMDR can make a difference in your life. I recommend this book to trauma survivors who are in EMDR treatment or considering treatment, as well as therapists who are being trained or considering being trained. —Colette Anderson, LCSW, CWC**

Adolescent Suicide: Prevention and the Pandemic

By Faith Voswinkle, Tim Marshall, & CTSAB

A death by suicide is a death like no other. It comes with shame, stigma, silence, worries for contagion, and so many unanswered questions. How could this have happened? What did we miss? Why? For many families those questions and more remain elusive and are perhaps never fully answered.

There are things we can do to mitigate suicide deaths. First, never be afraid to ask someone if they are thinking about hurting themselves or about killing themselves. They may express it indirectly, saying things like they wish they could "go to sleep and never wake up," or saying, "no one would miss me." We do know that trusted adults at school and home need to encourage and model open communication and create opportunities for youth to talk about how they are feeling. Collectively, we all need to work with youth, parents, educators, other trusted adults, and organizations in the community to nurture a compassionate community that provides a sense of safety and belonging for all.

Be the one to start the conversation…

The Impact of COVID-19

The COVID-19 pandemic and civil unrest in our country increased uncertainty for everyone, including youth, and we cannot underestimate the impact these factors have wrought. Physical and social distancing, increased isolation, school concerns, changes in relationships, worries for family and friend's health, and concern over the future of our country contribute toward increased anxiety and despair.

It is paramount that we specifically consider and address feelings of grief, loss, and disruption for youth. While the pandemic's disruption may be at the forefront of concern, other events and violence in our country, due to racism and the tumultuous election, have added to despair and anxiety.

Conversations around trauma and the pandemic have focused on the early days and all that was lost, but even now it can still be overwhelming. Even as we get back to "normal" life, the trauma and grief associated with COVID-19 continues to have lasting and lingering effects.

CT Youth Data

Between January 2001 and December 2020, Connecticut has lost 175 children to suicide. Boys accounted for 61% of those suicide deaths and girls accounted for 39%. For the past 8 years, girls have been dying at a similar rate as boys. Although the numbers are small relative to the total population, youth suicide has a devastating impact to the youth's family, school, and community, and the ripple effect of each tragedy cannot be overstated.

Youth Risk Behavior Survey

The Connecticut Department of Public Health administers the Connecticut School Health Survey (CSHS, which is also known as the Youth Risk Behavior Survey) every two years to students in randomly selected public high schools across the state. This is a national study designed and supported by the Centers for Disease Control and Prevention (CDC). Highlights from the 2019 CSHS related to risk and protective factors for self-harm:

48.3% of CT high school students said that in the past month, their mental health was not good for 3 or more days (including stress, depression, or other emotional problems).

30.6% of students felt sad or hopeless almost every day for two weeks or more in a row during the past 12 months. That's about 3 out of every 10 students, and more common in females. There has been an increase since a low of 22.8% in 2007.

24.1% of students said that when they felt "sad, empty, hopeless, angry or anxious," they get the help they need. That's only about 1 out of every 4 students getting the help they need.

About 12.7% of students seriously considered attempting suicide during the past 12 months, and this was more common among females.

What are risk factors for youth suicide?

- *Hopelessness, withdrawal from family or friends*
- *Anxiety, unable to sleep, or sleeping too much*
- *Dramatic mood changes*
- *Express no reason for living*
- *History of previous suicide attempts*
- *Family history of suicide*
- *History of depression or other mental illness*
- *Alcohol or drug use*
- *Stressful life event or loss*
- *Gender Identity*
- *Easy access to lethal methods*
- *Exposure to the suicidal behavior of others*
- *Perceived burdensomeness*
- *Lack of social support*

Protective Factors

- *Effective clinical care for mental, physical and substance use disorders;*
- *Easy access to a variety of clinical interventions and support for help-seeking;*
- *Restricted access to highly lethal means of suicide;*
- *Strong connections to family and community support;*
- *Support through ongoing medical and mental health care relationships;*
- *Skills in problem solving, conflict resolution and nonviolent handling of disputes;*
- *Cultural and religious beliefs that discourage suicide and support self-preservation.*

Connecticut Response to Suicide

The CT Suicide Advisory Board has developed a Postvention Protocol to ensure a timely, evidence-based response to youth and young adult suicide deaths in order to provide support to and reduce risk of surviving family, school, and community.

A system is activated through notification from the Office of the Chief Medical Examiner to the Office of the Child Advocate (as the statutorily mandated child fatality review entity). In turn, both the Department of Children and Families (DCF) and Department of Mental Health and Addicition Services (DMHAS) are notified in order to activate both adult and youth mobile crisis providers, Regional Suicide Advisory leadership, as well as the Regional Behavioral Health Action Organization (RBHAO), so that they can be responsive to the surviving family, school system, and community.

A Comment About Suicide and the Lifespan

One death is too many, and suicide is a leading cause of death for CT residents. On average, 403 CT residents died by suicide annually from 2015-2019, a 14% increase from the annual average of 351 from 2010-2014.

Adults age 18 and over account for 90% of suicide death in CT, and 74% are non-Hispanic, White males age 45 and over. Key factors in order of prevalence are: perceived depressed mood, poor mental health, intimate partner violence, poor physical health, and alcohol use. About half of people who die by suicide were in treatment for a mental health or substance use disorder, and half were not. CT calls to

behavioral healthcare prevention-intervention, coupled with community, work and family prevention-intervention strategies to help recognize, support and respond to those who may be considering suicide.

Recommendations for Prevention

Limit access to lethal means.

Lock up all prescription and over-the-counter medications. Lock up firearms, and store the ammunition separately. Youth almost always know where a firearm is located.

Know the warning signs when youth may need help.

These include changes in eating and sleeping, increased self-isolation, impulsivity, agitation, sensitivity, boredom and laziness, and reduced interest in typical activities.

Know what questions to ask.

A simple screening tool, such as the C-SSRS (Columbia Suicide Severity Rating Scale), to help determine a person's risk, and it should especially be used by health and mental health care providers, school systems, and police. Suicidal thoughts and behaviors occur along a spectrum, and the C-SSRS helps identify where someone is on the spectrum to support connections to the resources and care they need.

Prevent adverse long-term impact of this moment.

Incorporate recommendations from the Adverse Childhood Experiences Study (ACES) into prevention and practice.

Support and Information

Support in CT: Call 211 or visit
https://uwc.211ct.org/crisis/
https://turningpointct.org/

Crisis Call (800) 273-TALK (8255)
Crisis Text/Chat 24/7: 741741

CT Suicide Advisory Board & CT Regional Suicide Boards:
www.preventsuicidect.org

For Mental Health Promotion:
www.gizmo4mentalhealth.org

Violence Prevention:
www.cdc.gov/violenceprevention/pub/youth_suicide.html

Screening: https://cssrs.columbia.edu/

National Resources:
www.suicidology.org & www.afsp.org

Ask the Experts: An Interview With Theresa Leonard Rozyn

By Tammy Sneed, DCF

Theresa Leonard Rozyn is co-founder of The Underground, a grass-roots, faith-based non-profit group dedicated to ending sex trafficking and sexual exploitation in Connecticut. Rozyn was trafficked by her mother as a child and went on to become a sex worker as an adult. She talks about her journey to change her life and help others change theirs.

MS. SNEED: I'm Tammy Sneed, the Director of the Office of Human Trafficking Services for the state and Connecticut's Human Anti-Trafficking Response Team. I am here with a very special person, Theresa Leonard Rozyn, and we are going to talk about trauma, trafficking, and its impact. It's a lifelong journey that people tend to think once it's over, then it's over, but it's not. It's about how we can all work to better acknowledge that and support survivors on a very long-term basis. So, Theresa, thank you for agreeing to do this.

MS. ROZYN: I am honored to be here. I'll give you a gist of what my life has looked like. I was born exposed to alcohol and heroin. For the first five years of my life, I was "in the system." My mother was able to get custody back, she jumped through whatever hoops she needed to in order to get custody. I was the only one that she was able to get back. The others were adopted or not in a place to be back with my mom.

After that, from the age of maybe 6 or 7 to the age of 12 or 13, I was trafficked by my mother. I'll tell you something, I always believed that I was a prostitute. It hurts to say that word right now because I spent my life living that, prophesied it in all I did. I went to the sex industry, I became a sex worker, pulled in by drugs and alcohol. I didn't know a way out. I would stand there on the corner and I would watch people go into work and I would say, "that's not my lot in life."

And I see, and I pray for the women who are currently in that situation, because they are seen today. I see them. One of the things about being trafficked by my mother were the places—hotel, motel to motel, basically the Berlin Turnpike was the big thing—but there were other places in Connecticut. If my mother were here today, she would cash in on the internet. The saying was, "you can't pay, you can't stay." So, you have to be able to pay your way to stay here. For some reason, all I wanted to do was be there. As many times as they would take me away, I would find my way back. All I ever really wanted was family.

Over the years horrific things happened. I was sold to a truck driver, and he owned me for about 6 months. To this day when I see trucks, it shakes me a little bit. I don't want to be too graphic, but inside I want to give you the gist of what happened in those 6 months. In his truck he had a log and it had photos of women, and he said, "this is where you're going to go, this is your spot." He attempted to sell me to another truck driver and apparently the other truck driver was like, "are you out of your mind?" Anyway, the other driver stayed outside the truck and when the truck driver went into the store, he opened the door and said "you better run, honey. Get out of this truck and run. Scream, holler, yell. I know you're scared but run, run right now." I had never remembered that until recently, I only remembered the awful things that had happened to me. But that's what a life of healing looks like.

Six weeks ago I had a dream, then I woke up next and I didn't really know what the dream was. I have horrific, horrific nightmares. I have yet to find healing. I go through spurts where they're terrible and then I go through spurts where they're not. That's part of that healing process. I never remembered him. I only remembered that little piece, that feeling that, when he's done with me, he's going to kill me, and I am going to end up on the side of the highway. And for a while, I couldn't wait for that to come. I did not see a way out other than that torture.

(Continued from page 4)

And then, one of these dreams, I hear, "honey, I know you're scared but you have to get up and you have to run now. Go into the ladies' room and stay in there, we're going to call the police." And I am like, "Oh no! The cops." I convinced him not to call the police, and he just said, "this is so not you; you're going to die out here." Later I learned that he was in recovery from alcohol and drug addiction.

I am blessed by that memory today.

MS. SNEED: And you didn't have that memory until recently?

MS. ROZYN: About 6 weeks ago. Through healing, I can smile at that story.

MS. SNEED: And what a pleasant story. Right?

MS. ROZYN: Yes, yes, yes. I had shared it with a mentor team I am part of. I went in and I shared that. For some reason it just, it wasn't getting me. And then I went, and I sat with a clinician. We talked through every single word — "What does this word mean? When you hear this, when you hear him say, 'Sweetheart you have to go, you have to stand up and you have to run.'" I was able to really process that. As a survivor, you tell the story so much, it no longer has meaning. But those are the stories that have the most meaning!

Throughout those six months, terrible things happened to me. But I was rescued. I believe that God used that man to rescue me, because I do believe that I would have been a picture up on that wall, and that he was going to throw me off the side of the highway somewhere—wherever it is—that he does that.

MS. SNEED: It's really special for you. Some people listening to this from the very beginning are going to think, "really the whole story was just so terrible, that this happened to her." I've known you for a long time and I have heard you speak, you're tremendous, and you've really talked about that journey. To hear from you that there was that time that there was a person there for you, that just stuck out for you — that's so important. Lots of time people say, "what can we do?"

MS. ROZYN: A man! A truck driver — that is who came and rescued me. That is such a big part of this, you know, because I look differently at trucks. But there's a good one in there; you know what, there is someone in there saying "sweetheart, run." It puts a different color on my experience at that truck stop.

MS. SNEED: Now you've done a lot of education at truck stops, haven't you? How is that perceived when you're out there and you're meeting with folks?

MS. ROZYN: Well, I talk more about what it looks like when you see a woman at the truck stop, and you see her jumping from truck to truck, I emphasize that this is what's happening. Now, I tell them, "You can do whatever it is you want to do but at the end of the day the Department of Corrections saved my life many, many times over." So, calling the police isn't such a bad thing. It holds her accountable; it gets her help. She gets off that truck stop. Believe me, if I'd heard me talking—"Oh my God, this woman's trying to lock us up!" But it saved me, and it took me a long time to realize that. But corrections, the judicial system, I needed somebody. I would be dead today if I didn't bounce in and out of jail. So you may call the police, and that person may be taken, but you just never know what's going to happen in 10 minutes or 20 minutes. I'm not necessarily talking about the street, but I am talking about truck stops. Most of the women that they find on the side of the highway were picked up in one state and dropped off in another, and nobody's looking for them.

After 6 months of being kidnapped—abducted—I came back, and not one person knew that I was gone. Nobody noticed that I was gone, that these terrible things happened to me.

MS. SNEED: Theresa, who should have noticed—I ask this for the people who are going to be reading or hearing this—who should have noticed?

MS. ROZYN: A loved one, a sibling, a friend. A probation officer—I hate to say that, but the justice system has factored into my story greatly. [A school] would've been a good place, too.

…

I had the opportunity — for two years! — I went to prison. And the judge, as he was sentencing me, he was saying, "Miss Leonard, I am going to do you a favor today." I am like, "Yay, I am getting out!" And he says, "2 years." In those 2 years, I learned how to read. In those 2 years, I learned what abuse and abduction looks like. I didn't understand the trafficking part, but I definitely knew that that man did not have the right to take me. And up until that moment, I didn't; I just knew I got in the truck, and I'm his.

I hate that word, prostitute. I was described as a prostitute. I won a Women of Leadership Award from the YMCA, I'd been nominated for it, and through that my story ended up in the newspaper. When I got the award, they discussed my story; the woman who nominated me didn't know that what she said would be put in the paper, but she said that I was once a prostitute, and that I was now working in the inner-city to help women who had substance abuse issues and live in the street as well. And there was a reporter there, who interviewed me, and that's when that all happened.

I never thought that I could be seen. I really believed that I was never going to read or write, that I was never going to see outside of the sex industry.

...

You made a comment earlier, about how people expect healing [to be quick]. A lifetime of healing is a lifetime of healing. . . . For me, the past couple of years: nightmares. There were times that I would drive, and if I saw a truck driver, I would freeze. Just feeling fear and anxiety, and having no idea what that is. Or other times, learning to understand the capacity of love: that love isn't sex, that love isn't violence.

…

MS. SNEED: I hear you loud and clear about being called a prostitute at such a young age and how powerful that was — not in a good way. As we're trying to educate people across the state and across the country, we're very clear in saying that there is no such thing as a child prostitute. But people still struggle with that and that's so frustrating, right? You see lots of people, they totally agree and they're ready, and then you get some folks who seem to have a problem.

MS. ROZYN: How do you know what you don't know? I don't see it as something malicious, I just think some people don't understand exploitation. They don't understand that word, of being so desperate, acting from a place of desperation. I have heard women that I work with say, "Yeah, well, I was a prostitute," and I remember

for a couple years, I said that too. And then suddenly it left a bad taste in my mouth, and it hurt me to say that word. I would have done none of that if I was not desperate. Desperate to escape the situation that I was in. Unfortunately, that was the only life I knew.

If you've never had to make that decision from that place of desperation—I spent 20 years justifying who I was and how I got there, and this is a new path. I don't have to live in that place of desperation.

What I can do now is help people who are in that place of desperation. People who do need to detox. Whoever is lost and broken out there, I am looking for you. You haven't just disappeared — I am looking for you. Even if the people around you may not be, I am looking for you. You are seen.

MS. SNEED: Theresa, you've shared your tremendous story of what you went through; on your journey, what are some of the things that helped you to move forward and not give up at that moment?

MS. ROZYN: It goes back to that nomination, that was the first one: someone recognized that I could help someone else. Despite the use of the word prostitute, it spoke to the work I was doing, the outreach I was doing on the streets. I had very little sobriety at that point, but I went into this transitional program, and a year and a half later I worked there. I was a driver, and that's what I mean by those ten minutes: taking someone to a doctor's appointment, and all of a sudden you've earned trust—in just ten minutes, "I know you won't hurt me, I know you see me, I know I mean something to you." And there it is, that door is open. The ability to know that I see their pain, and that we'll walk through it together. That they're not alone.

This interview has been abridged for length and clarity.
To listen to the full conversation, visit:
www.womensconsortium.org/podcasts

Who's Been Reading Trauma Matters? Kelvin Young!

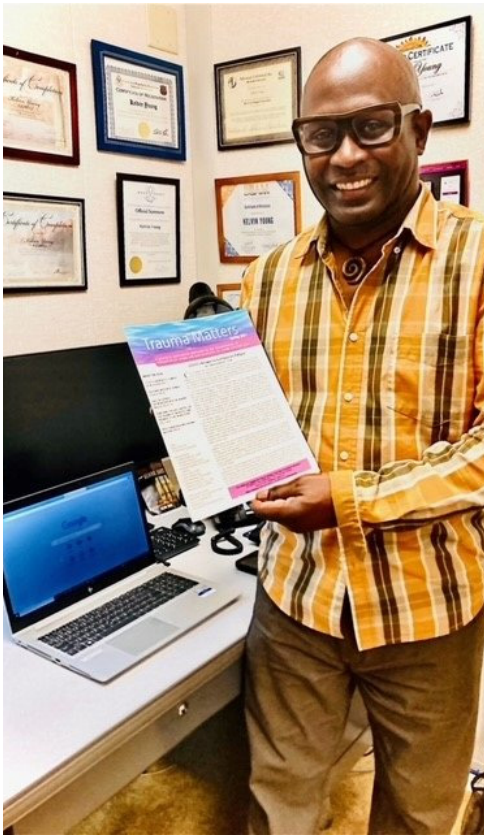
By Sharon Molloy

Kelvin Young is a certified sound healer and owner of Kelvin Young, LLC. The first time Kelvin was exposed to sound healing, he discovered that the sounds of the crystal and Tibetan singing bowls calmed his mind, relaxed his body, and nourished his soul. He went on to study sound healing with master sound healers Tony Nec of Sound Healing Academy, Zakiah Blackburn of The Center of Light, Paul Hubbert of the Holographic Sound and Inner Balance, and Satya Brat Jaiswal of the International Academy of Sound Healing. Kelvin has also studied with Brian Luke Seaward of Inspiration Unlimited, a renowned international expert in the field of holistic stress management.

Kelvin—who has been in recovery since 2009—is the co-founder of Toivo, a DMHAS-funded, recovery-focus holistic healing center in Hartford, CT. In 2020, he was inducted into the Connecticut Hall of Change, as a formerly incarcerated man who has made substantial contribution to Connecticut communities. Kelvin was featured in a powerful documentary on trauma, addiction, and recovery called Uprooting Addiction and is the author of Finding Freedom Behind Bars: A Journey of Self-Discovery & Healing where he shares his story of addiction and incarceration.

Kelvin sustains his recovery by eating a vegetarian and plant-based diet, practicing sound healing, deep breathing exercises, listening to uplifting and relaxing music, body movement, being in nature, reading, massages, resting and connecting with family and friends. He is passionate about holding space for people to heal and is known for his warm, loving, and down-to-earth way of connecting with people.

Kelvin is a frequent trainer at the Connecticut Women's Consortium. Kelvin's willingness to share his personal story of trauma, addiction, incarceration, and recovery continues to inspire us, and the community at large.



Kelvin Young, pictured above with a recent copy of *Trauma Matters*

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A publication produced by The Connecticut Women's Consortium and the Connecticut Department of Mental Health and Addiction Services in support of the Connecticut Trauma and Gender Initiative.

www.womensconsortium.org

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