TRAUMA MATTERS

Volume 2, Issue 4 Fall 2004

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

Submission of Articles

If you would like to submit an article about your agency's trauma groups, trauma training efforts or other trauma related topics, or if you are interested in becoming involved in the Editorial Board, please contact Carol Huckaby at: 203-498-4184 Ext. 25 or via e-mail at chuckaby @womensconsortium.org.

VOICES OF RECOVERY

When someone says, "I am in recovery," you might think that he or she means, "I am in therapy" or "I am in a program." Since recovery is oftentimes associated with kicking substance habits, you might think that he or she is working to get off drugs or alcohol. You might also think that someone who says, "I am in recovery" today will say that he or she is out of recovery in the near future. In clinical settings, the goal of treatment is oftentimes recovery from something, and because managed care companies determine what constitutes appropriate treatment these days, you might think that recovery takes six or 12 weeks, after which he or she will be recovered. When an addiction co-occurs with PTSD, however, recovery is not so neatly managed. Although past trauma may present itself as a current habit, when someone with a trauma history says, "I am in recovery," he or she means, "I am in the process of remembering." As Judith Herman explains in *Trauma and Recovery*, this process can confound someone with a trauma history since he or she must remember as well as integrate the past, understand the effects of his or her traumatic history, eliminate its negative consequences, and reconnect with the world. The substance habit might squash the flood of memories for a while or make remembering more bearable. Recovery, then, in the sense of getting off drugs or alcohol, might not be the most humane goal because traumatic history cannot be recovered from (it is a lifelong process, and part of his or her identity, whether remembered fully or not). Therefore, treatment for trauma requires something other than a six or twelve week group. Since one person's traumatic history is bound up with social history and the violent histories of others, the effects of trauma constitute shared experience. Consequently, when someone with a trauma history says, "I am in recovery," he or she also means, "please remember with me."

Submitted by Cara Hood
Southern CT State University

QUOTES FROM A MEN'S TRAUMA GROUP

Mark S. (May 2004)
"The group has been an integral part of the substantial growth and development I have experienced in the past year, as well as gaining overwhelming peace and understanding of my emotional well-being. I will sincerely miss the other members of our family, who have put aside all pretenses for the good of the group and all of its members, for the greater good of each individuals needs. But, I am also looking forward to the start of this group again, to begin the process again so I may learn how to give back. Because of this group, I have come to experience for the first time in my life true peace, happiness and contentment with the man who is becoming Mark S."

Thank you, your friend and bother, Mark S.

Eddie R. (March 2004)
"The men's group has helped me change my life. It has helped me learn ways to change my behavior and thinking, get self-acceptance and become a better person. This group has helped me to get better self-understanding so that I know who I am and what I need to change. Accepting myself and others is an important part of it too. I am learned so many important things in this group. "

Tim J. (March 2004)
"This group has taught me to be honest with myself and to realize that change doesn't happen overnight. Honesty is also not making excuses for my behavior. "

Jeremy T. (March 2004)
"The group has shown me that recovery is about changing my thinking and learning skills that will help me to deal with my life."

DMHAS' Definition of Psychological Trauma & Recovery

Mission

The Department of Mental Health and Addiction Services will deliver behavioral health care that is sensitive and responds to the needs of trauma survivors: Some of the values of this policy and operating principles that govern are listed below

Definition and Effects of Psychological Trauma:

- Psychological trauma involves events or experiences that confront the person directly or as a witness with the actuality or the immediate threat of death, extreme human suffering, severe bodily harm or injury, coercive exploitation or harassment, sexual violation, violence motivated by ethnocultural prejudice, or politically based violence.
- Psychological trauma has a direct impact on the brain and associated bodily and neurological and stress response systems. This causes imbalances in mood, memory, judgment, and involvement in relationships and work. The psychobiological impact of trauma leads to a sense of fear, helplessness, horror, detachment, and/or confusion.
- Experiences of interpersonal trauma (such as childhood physical or sexual abuse or neglect, or adult domestic violence) are a betrayal of basic human values and often cause lasting and severe post-traumatic impairment in the survivor's basic sense of self, trust in others, involvement in society and culture, and the health and integrity of his/her body.
- Persons with severe and persistent behavioral health problems, including mental illness and/or substance use disorders, often have experienced trauma. Many suffer from post-traumatic symptoms, which exacerbate their other behavioral health problems, impair their psychosocial functioning, and interfere with the quality of their and their loved ones' lives.

Meaning of Recovery:

Recovery is the core goal for trauma survivors, their families, and their treatment providers. Recovery does not necessarily mean complete freedom from post-traumatic impairment, as many survivors live healthy and rewarding lives while still having to manage post-traumatic symptoms. Recovery means regaining the understanding, support, and practical and psychotherapeutic assistance that enables trauma survivors to find within themselves a genuine basis for hope and personal, relational, and spiritual renewal.

From Connecticut Department of Mental Health and Addiction Services'
Policy on Trauma Sensitive Services

Spring Issue Survey Responses

In the Spring 2004 issue there was a one-page survey developed to invite feedback from readers about the newsletter. While the number of responses was low, the information obtained through those surveys proved helpful to the newly reconstituted 6-member Editorial Board. Members of the Editorial Board are Donna Brooks, from the STAR Program at CT Valley Hospital; Marshall Rosier from CT Counseling Centers; Valerie Leal from the Department of Mental Health and Addiction Services; Cara Hood, a professor at Southern CT State University, representing the CT Trauma Coalition and Carol Huckaby and Marijane Carey from the CT Women's Consortium.

The survey responses to the question "What do you find most helpful or informative?" were:

- Calendar of trainings;
- Information on the various models/approaches with different populations;
- Information on successful programs/best practices;
- Trauma initiative information and upcoming workshops;
- News of trainings and articles written about new groups and/or experiences in trying different models; and
- Gaining awareness of recent initiatives and various support programs.

Based on the compiled results of the surveys and insightful discussions at Editorial Board meetings, there was a consensus to expand the scope of the Newsletter. In every issue there will be:

- a different definition of trauma that will be selected from several sources including, but not limited to, the DSM-IV, clinicians, experts and consumers;
- information on upcoming trauma related events, such as trainings, conferences, books, movies and exhibits;
- research based articles with website links to national and federal trauma-related publications;
- voices of trauma recovery from consumers; and
- safety tips.

Submitted by Marijane Carey
CT Women's Consortium

CURRENT TRENDS IN TRAUMA TREATMENT

Although it has been less than 25 years since the inclusion of PTSD in the Diagnostic and Statistical Manual of Mental Disorders (DSM-3RD Edition, 1980), significant advances have been made in the assessment, treatment and research of psychological trauma and PTSD. And, while the study of PTSD has been of central importance to many treatment providers, researchers and legislators over the last few decades, the devastation and aftermath of September 11th, 2001 brought PTSD and trauma treatment to the forefront in the minds of many. Since that time many state and federal agencies, as well as public and privately funded treatment facilities have focused on the importance of assessment and treatment of psychological trauma and PTSD as a critical treatment priority. As a result of this increased emphasis, many important developments have emerged in the field to provide insight into the effective assessment and treatment of psychological trauma and PTSD. The increased emphasis on PTSD and psychological trauma is not unwarranted. PTSD is a significant public health issue nationally, and poses a considerable challenge regionally. A recent study conducted by DMHAS (2002-2003) found that 19.4% of all women and 12.2% of men entering treatment in Connecticut met the diagnostic criteria for PTSD. Providing effective treatment is reliant, in part, on research and innovation in this area in order to address this serious public health issue and towards developing effective treatment for trauma related disorders through the development of evidence-based practices.

The following is a brief summary of some of the recent developments and current trends in trauma treatment outlined by Rauch and Cahill (2003) and Ruzek, et al., (2003).

Please refer to these articles for expanded discussions of these topics

Individual Treatment of PTSD (Rauch and Cahill, 2003)

- ***Exposure Therapy*** - Clinically directed exposure to trauma-related or trauma-specific memories or feelings in order to decrease anxiety, avoidance and arousal
- ***Stress-Inoculation*** - Anxiety management approach that emphasizes teaching people to learn effective management skills of common PTSD symptoms
- ***Cognitive Therapy*** - Therapeutic reinterpretation and modification of events and meaning associated with traumatic experiences through the development of alternative beneficial thoughts
- ***Eye Movement Desensitization and Reprocessing*** - Combination of clinical interviewing, brief exposure to trauma-related memories, cognitive restructuring and eye movement exercises used to assist person to desensitize to traumatic event(s)
- ***Psychological Debriefing*** - Brief clinical interview that encourages person to discuss traumatic event and their beliefs, interpretations, and emotional reactions to the event
- ***Cognitive Behavioral Therapy*** - Combined psycho educational, skills-building and minimal exposure techniques to assist in developing better coping and to reduce symptoms severity.

Group Treatment for PTSD (Ruzek, et al., 2003)

- ***Group Support*** - Primary goal is to provide social support and encouragement for people affected by trauma experiences
- ***Group Education*** - Presentation of educational materials and content designed to normalize experiences, increase recognition of symptoms and decrease anxiety associated with traumatic memories
- ***Coping Skills Training*** - Empower people to manage their symptoms by learning effective coping strategies and techniques to improve PTSD related symptoms and associated challenges
- ***Therapeutic Exposure Groups*** - Repeated processing of traumatic materials in order to reduce fear and arousal associated with traumatic events
- ***Cognitive Restructuring Groups*** - Emphasis is placed on challenging negative or maladaptive interpretations and beliefs around traumatic events and development of more realistic and alternative beliefs.

Structured Cognitive-Behavioral Treatments of Co-Occurring PTSD and Substance Use Disorders

- ***Seeking Safety*** (Lisa Najavits) - A present-focused, skills-based approach to developing effective and safe coping skills utilizing several flexible modules designed around central recovery themes.
- ***Trauma Recovery and Empowerment-TREM*** (Maxine Harris) – A psycho-educational and skills-building approach that focuses on empowering trauma survivors to develop healthy coping skills.
- ***Trauma Adaptive Recovery Group Education and Therapy-TARGET*** (Julian Ford) – Strength-based approach that can be used for short, intermediate or long-term treatment that emphasizes self-regulatory skills-building and experiential exercises.

REFERENCES

- State of Connecticut Department of Mental Health and Addiction Services. RESEARCH REPORT: *Getting Better: A study of Addiction Services in Connecticut.* (2002-2003). Funded by SAMHSA and CSAT. Research conducted by University of Connecticut, School of Medicine.
- Rauch, S.A., Cahill, S.P. Treatment and Prevention of Posttraumatic Stress Disorder. *Primary Psychiatry*, 2003, Vol.10, #8(60:65).
- Ruzek J.I., Young, B.H., Walser, R.D. Group Treatment of Posttraumatic Stress Disorder and other Trauma-Related Problems. *Primary Psychiatry*, 2003, Vol.10, #8 (53:57).

Submitted by Marshall Rosier
CT Counseling Services

Safety Tips

With fall approaching our days are getting shorter. The following Safety Tips can keep you out of harms way!!!

- Look before you leap. Look around your car and the parking lot or driveway for strangers, strange vans, cars etc before approaching your automobile. If you see something that you think is amiss, do not approach your car, go back into a building/house and get assistance.
- Always have your car keys in your hand before you leave a building or home. Fumbling in your purse or knapsack for keys makes you a prime target for mugging or abduction.
- When you get in your car (at home or away), lock the doors immediately. Then start the engine etc.

Consortium Fall Trainings

The CT Women's Consortium, a statewide policy, training and advocacy organization specializing in women's behavior health is offering several trainings to help create a system of care for women that is trauma sensitive, gender specific, and culturally relative. Some of the trainings are new such as the three-part series entitled *Behavioral health Issues for Women: A Multicultural Perspective and Understanding the Parental Rights of Parents with Behavioral Issues, and Navigating the Medicaid System,*. Other trainings offered include the following topics gender specific assessment, empowerment, strength based approach to service delivery, domestic violence, and women and homelessness. All of these trainings further the goals of the Department of Mental health and Addiction Services' Recovery Initiative as well as its new Women's Services Practice Improvement Collaborative. The Collaborative is designed to create a best practice system of care for women that is supported by system-level policies and standards and program-level practices.

You can access our training calendar, registration forms and detailed information about each training at www.womensconsortium.org or by calling 203-498-4184 ext 30.

Getting into Trauma Matters

- You can access an electronic version of the "*Trauma Matters"* Newsletter at www.traumamatters.org; www.dmhas.state.ct.us; or www.womensconsortium.org
- Do you want to be placed on our mailing list or is there an event or topic you would like covered in this newsletter? Please call "*Trauma Matters"* editor Carol Huckaby at 203.498.4184, x25 or e-mail her at chuckaby@womensconsortium.org.

The CT Women's Consortium
205 Whitney Avenue
New Haven, CT 06511