Trauma Matters

Special Edition: Veterans Affairs

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

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Military Sexual Trauma

Individuals who experience sexual trauma while serving in the military can face a variety of medical and mental health problems related to that trauma. Veterans Affairs (VA) provides assessment and treatment for anyone who reports military sexual trauma (MST).

What is MST?

MST is defined by law (Title 38 U.S. Code 1720D) as "psychological trauma, which in the judgment of a VA mental health professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training." Sexual harassment is further defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character."

MST includes any event where a service member is involved in sexual activity without giving consent. Examples of experiences considered to be MST include being physically forced to have sex against one's will; being pressured or coerced into sexual activity (e.g., threatened with unwanted consequences if one does not or promised rewards if one does); or being involved in sexual activity when unable to give consent (e.g., when unconscious or under the influence of a substance). MST also includes sexual harassment, such as offensive remarks of a sexual nature, unwanted sexual advances or threats, or sexual touching or grabbing.

Determining how often MST occurs is difficult because many service members who experience sexual trauma do not report it at the time. However, survey studies of veterans have found that as many as 48% of women and 12% of men report experiencing sexual trauma while serving in the military. Among individuals who receive care at the VA, 1 in 5 women and 1 in 100 men report MST. Because the VA treats more men than women, about as many men report MST as women do.

What care are individuals reporting MST eligible to receive?

Individuals who report MST are eligible to receive care for any problem VA providers judge to be related to (caused or exacerbated by) the MST. VA policy is to ask all veterans, at their initial visit, whether they experienced MST, and VA medical centers are measured as to how effectively they do this. For individuals reporting MST, any care they receive for a problem related to it is free of charge, including medical visits, medical procedures, therapy, medications, and other services.

All individuals reporting a history of MST are eligible for evaluation by their VA health care providers to determine whether they have any problems related to it. Eligibility for the free care has no expiration date, and is not related to service connection; nor do veterans have to submit a claim. Individuals may be eligible for MST-related care even if they are not eligible for other VA services. For example, an individual who did not serve in the military long enough to qualify as a veteran but who experienced MST while in the military would not be eligible for VA services in general but would be eligible for MST-related care.

Every VA system has a staff person designated as the MST coordinator. That person ensures that the VA meets standards for MST-related assessment and staff training. The MST coordinator also educates staff and veterans and helps individuals reporting MST receive the most effective treatment for the problems they experience.

Military Sexual Trauma
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How does MST affect individuals who experience it?

MST is associated with a wide variety of medical and psychiatric difficulties. Individuals who report MST are more likely to be diagnosed with gastrointestinal problems, chronic pain conditions, chronic fatigue, liver disease, chronic pulmonary disease, gynecological symptoms, and sexual dysfunction. They are also more likely to be diagnosed with post-traumatic stress disorder (PTSD); mood disorders, such as depression or bipolar disorder; psychotic disorders; and substance use disorders. Research on the frequency of PTSD among veterans indicates that veterans reporting MST are 2 to 3 times more likely to be diagnosed with PTSD than are veterans who have been deployed to combat zones.

What treatments are available for problems related to MST?

MST itself cannot be treated. It is a historical fact, an event that happened to someone in his or her past. It cannot be changed. However, all the medical and psychiatric problems associated with MST can be treated. Care for individuals reporting MST in the VA begins with a thorough, careful assessment to identify any medical or psychiatric difficulties the person may have. The individuals are then referred for the best available treatments for the specific problems that are diagnosed.

Individuals who have experienced MST can find it difficult to receive treatment. Health care providers believe that one reason MST can cause so many difficulties is because it happens during military service. These individuals may have been harmed by someone close to them, and therefore may not have been supported by other peers or authority figures. As a result, they can often have difficulty trusting health care providers or anyone in authority. Health care providers must work to restore this trust by providing excellent care in a kind, compassionate, empathetic way and providing the individual with as much control over the process as possible.

For more information, please contact your local VA and ask for the MST coordinator, who will answer any questions and help individuals reporting MST connect with treatments that can help.

Submitted by Jason C. DeViva, PhD
Trauma Coordinator, VA Connecticut System (HCS)

In the News:
Senator Chris Murphy Introduces Bill to Expand Mental Health Services for Veterans

Too many veterans risk their lives for this country and return home from combat with mental health and behavioral health issues like post-traumatic stress disorder or traumatic brain injuries. Instead of getting the care and treatment they need, they're given other-than-honorable discharges or so-called "bad paper discharges," disqualifying them from VA care, including mental and behavioral health services. This isn't how we should be treating those who served our country. That's why I introduced the Honor Our Commitment Act in Congress to require the Department of Veterans Affairs to provide these critical mental health and behavioral health services to diagnosed former combat veterans who have been other-than-honorably discharged. My bill would also make sure veterans get access to these services in a timely manner and require the VA to justify any denial of benefits to Congress. Our veterans made a commitment to our country when they signed up, no matter the physical, mental or emotional trauma they'd endure. We need to keep our commitment to them, and I won't stop fighting until they get the care and benefits they deserve.

Submitted by U.S. Senator Chris Murphy
U.S. Senator Chris Murphy represents Connecticut in the U.S. Senate

Post-traumatic Stress Disorder and Suicide Prevention

The numbers are staggering: The Centers for Disease Control and Prevention (CDC) indicates suicide is the 10th leading cause of death, with over 44,000 people having died by suicide in the United States in 2015 (CDC, 2017). Among veterans, the prevalence rates are even higher; the risk for suicide is 21% higher among veterans than US civilian adults. Although it is difficult to ascertain exact numbers, recent data indicate an average of 20 veterans die by suicide each day (U.S. Department of Veterans Affairs, 2016).

The relationship between post-traumatic stress disorder (PTSD) and suicide is important to note. PTSD is often associated with suicidal thoughts and behaviors, as well as death by suicide (Bryan, Cukrowicz, West, & Morrow 2010; Wisco et al., 2015). Irrespective of trauma type (e.g., combat, sexual abuse, etc.), trauma exposure often serves as a risk factor for suicidality. As such, suicidality among individuals diagnosed with PTSD is inherent in clinical work with the veteran population, but how clinicians, practitioners, and agencies evaluate and address such risk widely varies.

Attending to the dynamic nature of suicidality is one of the most important aspects of clinical practice. There are numerous publications related to suicide risk assessment, yet there are no universally agreed upon guidelines for approaching suicide risk assessment and reducing suicidality. The Suicide Prevention Program at the Veterans Affairs (VA) Connecticut Health care System provides daily collaboration and consultation between clinicians aimed at accurately identifying the level of suicide risk and subsequent management of these risks. However, not all clinicians have access to similar services in their community practice and thus are left to navigate these areas with less support. Presented next is a series of common misconceptions regarding assessing for suicidality among the veteran population.

"Asking someone about suicide will exacerbate thoughts of suicide," and ***"If I tell my clinician that I have thoughts of suicide, they will definitely hospitalize me."*** Neither statement is true. A thoughtful inquiry about suicide, including past and present thoughts and behaviors, is more likely to convey the message to a client that you are open to hearing what the client is experiencing. Inviting a collaborative discussion with that individual and understanding the unique vocabulary the patient uses to convey his or her emotional distress can further serve to strengthen this critical and potentially life-saving dialogue.

"I kept telling people I am tired; I am tired. I wanted to tell them that I was having thoughts of suicide, but I was afraid to say that out loud," and ***"I was isolating, more than usual."*** When talking with veterans in my role as suicide prevention coordinator, I like to use the analogy of the sweeping arm of a radar scope. A radar scope may detect objects in its path, but discerning whether or not this blip on the radar screen is a threat requires additional information. There may be a perfectly plausible explanation as to why someone may be saying "I'm tired" or "isolating more than usual," but it is impossible to know unless we ask. There is no evidence to indicate that asking these questions increases suicidal ideation or risk.

"I don't want to turn the patients off, offend them, or lose the chance to engage with them by asking something so direct [specifically suicide-related questions]." It can be difficult to ask the straightforward question, "Are you having thoughts of killing yourself?" Even esteemed clinicians at all points in their careers may struggle to ask "the question." The phrase "denies suicidal ideation/homicidal ideation (SI/HI)" has become so overused that it no longer conveys the intended sentiment. Although each case is different, there is no research to indicate that asking questions related to suicidal risk damages the therapeutic relationship.

"If someone wants to die by suicide, there is nothing you can do about it." False. After surviving a near-fatal jump from the Golden Gate Bridge, Kevin Hines describes that while he didn't tell anyone of his plan to die, he had hoped someone (his brother to whom he had given a valuable comic book collection, the bus driver who drove him to the bridge without acknowledging his tearful face, nor the tourists at the apex of the bridge who asked him to take their picture moments before he jumped) would simply acknowledge that he was suffering. Knowing what to recognize and how to ask important questions is critical.

As a clinician, seeking consultation and securing appropriate levels of care are key to ensuring the safety of at-risk clients. The Connecticut VA's Suicide Prevention Program assists in connecting to mental health care services and other resources intended to help veterans and their families engage in care. Suicide prevention coordinators are available as a resource for all veterans who may be struggling with a wide array of mental health and access issues. Veterans who have been identified as high risk receive an enhanced level of care, including missed appointment follow-ups, safety planning, and increased frequency of contact during vulnerable periods.

The risk for suicide is inherent in clinical work with those who have experienced trauma. Understanding the common misconceptions surrounding suicide and how to access resources available for both the clinician and client before a crisis is central to prevention. Veterans can seek support through the Veterans Crisis Line (1-800-273-8255) a free, confidential, and anonymous resource with options to text, chat online, or speak to a responder. Non-veterans can seek help through the National Suicide Prevention Lifeline (1-800-273-8255) or Infoline (211).

Submitted by Mark Lawless, LCSW
VA CT HCS, Suicide Prevention Coordinator

Leaning into Fears: VA Connecticut's PTSD Rehabilitation Treatment Program

Evidence-based psychotherapies for post-traumatic stress disorder (PTSD) are widely available throughout Veterans Health Administration (VHA) outpatient mental health clinics. Many veterans choose to engage in time-limited, weekly, outpatient psychotherapy. They are able to successfully complete treatment over the course of several months while living at home and participating in their regular daily routine involving family, work, school, and community activities. However, some veterans benefit from, or find they may require, a more structured and supportive environment in which to engage in treatment for PTSD. Residential treatment programs specializing in PTSD provide evidence-based treatments in a sober, therapeutic milieu emphasizing peer support and daily therapeutic activities.

In fiscal year 2016, VHA provided 246 Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) across the country, with a total of approximately 8,000 residential beds. What we recognize now as the MH RRTP level of care represents the Department of Veterans Affairs' (VA) oldest health-care program, dating back to the 1860s when domiciliary care was established to provide housing for disabled Civil War soldiers. The MH RRTPs have evolved to provide specialized psychiatric and substance abuse treatment, in addition to ongoing support in addressing unemployment, homelessness, and functional status, to improve quality of life for veterans while decreasing reliance on and use of inpatient level of care and resources.

VA Connecticut is home to one of VHA's 42 PTSD-RRTPs; it has provided a residential level of care for PTSD treatment since 1993. Over the past 25 years, the program's treatment model has evolved along with advancements in the field and the changing needs of returning veterans and their families. Notably, evidence-based psychotherapies for PTSD, including cognitive processing therapy and prolonged exposure, are offered and recommended as first-line treatments to every veteran entering the residential program. These evidence-based psychotherapies are opportunities for veterans to engage in intensive trauma-focused individual psychotherapy with the goal of reducing trauma-related distress

and symptoms as well as improving overall quality of life and relationships with loved ones. Daily group therapy focused on the development of active coping skills further emphasizes healing from trauma through strengths-based skill building and relationships with others. Clinical case management services address and support co-occuring disorders, ensuring veterans have access to both behavioral and medication-assisted treatments for substance abuse disorder, as well as adjunct treatment for co-occurring issues including pain management, traumatic brain injury, medical care, and overall health and wellness.

Veterans eligible for PTSD-RRTP have been diagnosed with PTSD and identify it as a current, primary presenting problem. These veterans have previously attempted treatment for PTSD at a less restrictive level of care (i.e., outpatient care) but have been assessed to require residential rehabilitation services. Reasons for such care may include high potential for relapse, severity of symptoms, co-occurring disorders requiring additional treatment or attention, complex psychosocial needs or issues, and/or lacking a home environment conducive to recovery. Veterans entering residential care for PTSD often arrive with a basic foundation of skills for relapse prevention and emotion regulation, and they are generally psychiatrically and medically stable. It is also important for veterans to understand they will be engaging in a rigorous course of trauma-focused psychotherapy, including daily homework and group-based treatment, including community reintegration activities.

While the focus on veterans working together to define and pursue meaning and purpose in their lives has been a key theme of treatment since the program's origin 25 years ago, there have been recent efforts to strengthen and refine this aspect of the mission. Veteran's Council provides opportunities for veterans to take on leadership roles within the program and make important contributions to the program's culture of recovery and healing. Occasions for community reintegration through recreational outings and activities, volunteering, planning for returning to work or school, reconnecting with family, and rejoining community life are part of daily programming. VA Connecticut's PTSD-RRTP has been fortunate to have had certified peer support specialists on the multidisciplinary treatment team since 2008. Peer specialists use their personal recovery experience, along with motivational interviewing techniques and peer counseling skills, to help veterans identify goals, work through barriers, and take concrete, specific actions toward achieving meaning and purpose.

PTSD-RRTP staff strive to maintain the rich history and traditions of the program while ensuring that veterans have access to the most up-to-date evidence-based treatments and adjunct therapies, all while honoring the legacy of the veterans and staff who have shaped the program over the past 25 years. New areas of focus include the continued implementation of measurement-based care in which veteran responses on standardized measures are used to inform and evaluate progress in psychotherapy. The veteran and therapist review results together, discuss how they each understand the meaning of the collected information, and work together to make decisions about modifications in treatment planning.

Veterans often describe the VA Connecticut's PTSD-RRTP as "different" from other programs. The small census, intensity and focus of treatment, level of collaboration between veterans and staff, and the high expectations for working hard, taking responsibility, and helping others have traditionally set us apart. The therapeutic milieu is an important agent of change and provides veterans with opportunities for developing healing, healthy relationships. This supportive residential environment helps veterans gain confidence to engage in intensive individual and group psychotherapy. VA Connecticut's PTSD-RRTP's motto, "lean into fears," encourages veterans to take supported, purposeful actions to improve their quality of life and to define and fully live out their civilian mission.

Submitted by Alison Went, LCSW
Program Director, VA Connecticut PTSD-RRTP

Ask the Experts: A Conversation with Amy B. Otzel, MA, MS, LPC

By: Cheryl Kenn, LCSW

Amy Otzel is a retired U.S. Army behavioral health sergeant, Iraq War combat theater veteran, and former Veterans Affairs (VA) readjustment counseling therapist. Specializing in holistically minded, integrative mental health, Amy is continuing her mission to serve military members, veterans, and their families in private practice at Inner Resource Psychotherapy. Amy is a Yale University Department of Psychiatry lecturer, holistic health facilitator at Toivo by Advocacy Unlimited, and research collaborator examining the potential benefits of homeopathic remedies tailored to support combat-related post-traumatic stress disorder.

How did you first start working in the trauma field treating veterans? How has your work shifted since you entered the field?

As a teenager, I delved into research about the Vietnam War. While I could not imagine how any human could bear the burdens of war, I was further aggrieved to consider the impact of returning to heal in one's homeland and being painfully rejected by society. Alarmed by the immeasurable wounds of our nation's veterans, I realized my mission and moved purposefully to be in service to those who serve.

I enlisted in the Army as a behavioral health specialist and had one tour in Iraq. Upon homecoming, I struggled significantly, realizing that I, too, was not exempt from war's horrors and that an integral piece of my work would require both suffering and healing. While healing, I pursued graduate studies and served as a readjustment counselor with the VA. As I advanced my studies in integrative health and progressed in my wellness, I grew out of the systemic constraints and entered private practice. It has been my privilege to continue the mission facilitating empowerment-based trauma healing and stress recovery with military members, veterans, and their families.

What have been your most significant revelations in working with trauma?

The condition of those grappling with traumatic stress is the most imperative one to emphasize and hold in compassionate therapeutic presence. Ensuring mindful, encompassing, continuous collaboration and jointly cultivating and maintaining safety and connection while honoring unique personhood is paramount. It takes precedence, at all times, to inspire one's healing from trauma. Individuality is not part of military culture; moreover, one's personhood, fragmented by the trauma itself, is often further reduced by systemic processes and mechanistic viewpoints. Regard for the person enduring the trauma is preeminent. With that, reconnection to self, others, and the world around the individual can be stirred to lay the groundwork for self-empowered recovery and bring further efficacy to therapeutic processes. Additionally, symptoms are generally connoted with pathology and deficiency, often deterring veterans from continuing counseling. A major barrier is alleviated by shifting frameworks, intervention, and language to be more consistent with the strengths and proficiency-based military culture.

How would you say trauma-informed care for veterans has changed throughout your career?

It has become more cognizant of holistic effectiveness along with the benefits of implementing multimodal methods to promote healing. Recognizing that the problems incurred by traumatic stress impact all layers and aspects of one's biological, psychological, relational, and spiritual lives dictates a whole-warrior wellness approach. Military culture promotes collaboration, having multiple action plans, and ingraining myriad tactics to negotiate any situation. I envision a continued shift to appreciation toward and promotion of person-centered traditional and conventional modalities provided by a team who maintains continuity and connection.

What is the most important skill or tool in working through resistance with the veteran population?

Resistance is often considered a domain of constraint in the therapeutic process; however, I view it as a field rich with openings for growth. I take great care and intention not to resist resistance. I move fluidly alongside, as a journeyer, in support of a client's natural flow. The veteran population is quite necessarily proficient in maintaining tactical posture, adhering to operating orders, and not letting their guard down. It is, therefore, only expected for a veteran in the therapeutic process to be "resistant." The warrior, encapsulated in rule, order, and structure, maintains a sense of safety. Examining conditions of change can amplify one's force protection. Likewise, stress and trauma reactions ignite more protection.

With this perspective and the individual's condition in prime focus, this expected nature can be better understood as his or her way of relating to the world rather than a resistant circumstance of noncompliance or preventive impasse. I remain attuned to the themes underlying those important protective sheaths and with compassionate curiosity join the warrior to examine suffering, explore fears, and unearth wisdoms. I intend never to facilitate from my own fear, remain unattached to any outcome, and strive to offer bright therapeutic visibility. Information or "intel" supports a service member's sense of safety and preparedness when engaging an operational vulnerability. Therefore, I routinely provide rationales, conceptualizations, and psychoeducation to maximize the potential of creating healing opportunity.

What would you say are the most important take-homes for trauma-focused clinicians working with veterans?

Bring a beginner's mind to each encounter. Hold the personhood and uniqueness of the individual's encompassing experience in highest regard. Honor the inseparability of mind, body, and spirit. Continually cultivate safety, trust, relationship, and connection. Move fluidly with resistance. Practice from a place of openness and integrity. Emphasize strengths, skills, competencies, and values. Trust that each person possesses within him- or herself exactly what is needed to heal from trauma.

Arm with information to support creating opportunities and empower growth and healing. Support the mobilization of resources. Be an advocate throughout the rigor of navigating the spectrum of systemic benefits and accessibility burdens. Recognize the privilege of being invited to support another's healing and inspire such healing in line with the warrior's own values, beliefs, and plans for growth. Finally, ensure a network of support for the great work that you do while maintaining self-care and turning compassion inward.

To me, there is no greater honor than continuing the mission in healing service to those who have served. Our men, women, and families in arms can find great healing by being embraced within the community they so courageously and selflessly served. As a profession, we can all contribute some for those willing to contribute their all.

Want to support CT veterans?

The VA CT HCS depends on the goodwill of those looking to give back to America's heroes. Think about supporting the VA by volunteering or giving a cash or non-cash donation today!

For more information: connecticut.va.gov/giving/
or call your local campus:
Newington Campus: (860)667-6718
West Haven Campus (203)937-3814

Featured Resource:

The National Center for PTSD

Submitted by Eileen Russo, MA, LADC

A lot has changed since The National Center for PTSD (NCPTSD) was last highlighted as a featured resource in Trauma Matters in 2005. What remains the same is that the website is full of fact sheets and up-to-date information around research and education on PTSD and trauma. Since 2005, the website has been revamped with a new organizational layout and designated areas for the public and professionals. In the section for the public (defined as general public, veterans, family and friends), there is a mobile app and a PTSD online coach. The online coach includes several topic areas, including changing negative thinking patterns and relaxing through breathing. Each topic utilizes tools including worksheets and brief videos. The section for professionals offers some free on-line training, consultation, and the Pilots database allowing for access to PTSD and trauma related literature from around the world. In addition, there are also free on-line newsletters available. If you do not work with veterans, do not let this deter you from this helpful website, there is something useful for everyone.

Access the website here: https://www.ptsd.va.gov/

The mission of the VA Connecticut HCS Hospital Education Service is to…

…provide continuous, current, and relevant education to patients and staff utilizing evidence that supports learning, competency, and professional growth and creates improved patient outcomes. Clinicians employed at the VA Connecticut HCS are provided specific learning that helps them to develop competency in Trauma Care. The following topics are assigned to identified staff to help enable their ability to provide care to veterans with a trauma diagnosis: Traumatic Brain Injury, Military Sexual Trauma, Initial Post-traumatic Stress Disorder (PTSD) Examination, and the Disability Examination Process.

Submitted by: Sadiann Ozment, RN, MPH
Chief, Hospital Education, VA Connecticut HCS

The Connecticut Women's Consortium
2321 Whitney Avenue, Suite 401
Hamden, CT 06518

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www.womensconsortium.org

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