TRAUMA MATTERS

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An electronic version of the Trauma Matters Newsletter is available at www.womensconsortium.org

IN THE AFTERMATH OF SANDY HOOK:
One Person's Point of View

Opinions are mounting as educators, mental health professionals, lawmakers and many other advocacy groups try to make sense out of the recent tragedy in Newtown.

At the Connecticut State Capitol, people were trying to make their voices heard. On January 28th 2013 there was a hearing on gun control followed the next day by a hearing on mental health. On January 30th there was a rally to support private nonprofits and to keep budget cuts at bay demanding that when we are already serving more people with less money and increased workloads that the "safety net" not be further eroded for people with disabilities.

People in CT are demanding answers and they want what they perceive as a broken system of care fixed to help those who suffer from mental illness. While there is room for improvement, some of the assertions are based on an incorrect premise. There has been no evidence provided to citizens that demonstrates that the perpetrator at Sandy Hook had been diagnosed with mental illness. What we do know is that he was considered different (a loner who attended school with a briefcase) and left his school system to be home schooled.

For those of us with experience in the mental health field we know that through many years of budget deficits, cities have struggled to keep mental health professionals in the school systems. Some towns have one school social worker to cover the entire area. Other towns have split their staff across several schools. The number of positions for school psychologists and social workers has been diminished to the point where staff trained as career counselors or guidance counselors often get pulled in to handle matters. In many of these cases, these workers are trained to assist students with educational decisions, like getting into college or choosing courses, but they are not licensed professionals trained in behavioral health.

We all know that trauma really does matter. National community-based surveys find that between 55% and 90% of us have experienced at least one traumatic event in our lifetime. Studies show that evidence-based trauma treatment models do work. Connecticut should take pride in its efforts to bring these trauma-specific treatment models and other aspects of trauma-informed care into the state branches such as Department of Children and Families, Department of Mental Health and Addiction Services, Court Support Services Division and the Department of Corrections, but what about our school system? Have we done enough? The behavioral health services available in school systems needs to be enhanced. Vital positions need to be funded and schools need to be connected to local behavioral health clinics. The good news is, conversations and actions are moving in the right direction. Just this March, in response to Newtown, many of our cities and towns have made a renewed commitment to fund mental health services in schools reflecting an increased understanding of trauma and its impact on child development.

Let us all continue to partner to help increase behavioral health capacity in our school systems beginning at the Head Start level with infants, toddlers and preschoolers right through high school. All our children deserve access to behavioral healthcare from birth so let's give it to them.

Submitted by Colette Anderson

Picking up the Pieces —Using EMDR to Address Recent Traumatic Events

Imagine a bottle slipping through your fingers and falling to the tile floor in a kitchen. Shards scatter, slivers lodge under the stove and tiny, sparkling fragments settle in the grout between the tiles. As you clean up, you start with the biggest, most obvious pieces, but some of the debris might elude you. The impact of trauma is not unlike the falling bottle metaphor. Something startling happens; we survey the wreckage in shock and then attempt to pick up the pieces. Over time, some of us get all of the glass in the garbage. Others may have painful encounters with the residue or find fragments so embedded in the fiber of their being that it creates a painful pattern of reactivity. How trauma gets processed, or in this example how well that floor gets cleaned, is based upon a number of factors—the nature of the trauma itself, our developmental status and strengths at the time, our trauma history, and the supports available to us before, during and after the event.

Most trauma therapists tend to work with consolidated memories of negative past experiences, often situations that took place years ago. Therapists who use an evidence based therapy called Eye Movement Desensitization and Reprocessing (EMDR) ask clients to recall the memory, asking for an image that captures it, the negative self-referencing cognition learned in relation to the event, the more positive/adaptive cognition the person would like to have about themselves, and the emotions and body sensations evoked when recalling the event. Clients are then asked to pay attention to these sensations/thoughts while simultaneously attending to bilateral stimulation (eye movement or tapping). The guiding principle of the approach is the idea that traumatic events can overwhelm the brain's natural ability to process difficult material and adapt, leaving aspects of the traumatic event lodged in the system, like an unwanted splinter, causing pain and dysfunction. The EMDR process helps the client to desensitize and process disturbing recollections (or remove the splinter) which then allows the brain's natural healing process to kick in. Difficult memories become less troubling and new, more adaptive, information and coping skills can be accessed. But, what about recent trauma? Can EMDR therapy be used to address the impact of a recent traumatic event and is the process different?

Hundreds of people have been impacted by the recent school shooting in Sandy Hook. Tragedies like this hit communities in waves. The first wave floods the victims, families and immediate community, the next tumbles over the first responders and their loved ones, later teachers, parents, and people who have survived trauma and loss in the past from other communities can also feel the pull of the water.

As a volunteer involved with training and supporting clinicians assisting Sandy Hook community members, I had the opportunity to debrief therapists about their experiences. As I listened to one clinician talk about her work in that community, I didn't hear just one disturbing memory, I heard a series of troubling incidents. "On the day of the shooting, I was in a meeting and suddenly everyone's phone started to ring, I thought to myself, *something really bad must have happened and was instantly filled with fear.* Later, after I had more details, I thought about the people I knew from that area and panicked worrying about them. Not long after, I found myself *thinking of my own past losses and became sad as I considered an impending loss.* Once assigned to go to the area to assist, I had concerns about my own ability to be helpful*; I feared I'd be overwhelmed by the task of helping people in so much pain*. As I drove into the area the next day, *I was overwrought thinking about the suffering of the parents and family members* and was stunned by the image*s* I saw when I neared town: a funeral procession, signs on the highway overpass written in support of the families, and a pile of teddy bears in front of a line of burning candles. After listening to the stories of so many people, *some of the images they described seemed frozen in my brain*. *At night the images returned in my dreams*. On the rides home *I often felt guilty that I couldn't give more time to help out.* Since this started, I've found myself more tired and preoccupied. And *I feel guilty about this too*, I was fortunate not to have been directly impacted, am grateful for the opportunity to help, yet, *felt weak* because the small amount of help I did provide was so draining on me."

In debriefing someone who has assisted with a recent traumatic event or when working with someone in the epicenter of a tragedy, one hears the event as a series of images, cognitions and feelings. The event is not a consolidated story yet. If one year later I were to ask the clinician I debriefed to talk about the memory it would more likely come back to her as one episode, one striking memory, such as something a particular family member told her or the sight of the funeral procession as she entered town. She may tell me that those memories have faded and don't trouble her now, or she might report they still make her anxious. EMDR trained therapists address recent trauma by addressing each part of the story as an individual target or event through the use of recent event protocols. The goal is to decrease current distress and hopefully prevent the development of Post Traumatic Stress Disorder (PTSD) down the road.

This is a simplistic explanation of a complicated issue. For more information about how EMDR therapy can assist those impacted by both recent and past trauma, or to find out more about how to get trained in EMDR, please go to the following websites: www.emdr.com or www.emdria.org The Humanitarian Assistance Program (HAP) trains full time non-profit or public sector clinicians for a reduced fee. Contact:www.edmrhap.org for more information.

Fairfield County Trauma Recovery Network (TRN), an affiliate of the EMDR Humanitarian Assistance Programs, is a team of licensed, seasoned EMDR therapists trained in disaster response. They offer treatment to first responders

and public education about vulnerable populations in the aftermath of community disasters. For more information about this TRN, contact either Co-Coordinator of the Fairfield County Network: Michael Crouch, LCSW crouch.wm@gmail.com or Karen Alter-Reid, Ph.D. karen.alterreid@gmail.com

Submitted by Hope Payson LCSW, LADC

What To Say to Your Children When a Tragic Event Occurs

The recent horrific Newtown tragedy evokes a myriad of feelings: disbelief, fear, anxiety, apprehension, anger, rage, grief, sorrow, incomprehension, vulnerability and helplessness.

It is important for all children and teens, but especially for young children who will inevitably hear a version or versions of this tragedy and unfortunately other similar future tragedies to be able to absorb the event insofar as age appropriateness permits and to feel safe and secure despite its horrifying nature. Parents who are likewise in the throes of struggling to understand this tragedy will have the responsibility to provide that sense of safety and security and to provide a needed sense of reassurance.

The National Child Traumatic Stress Network (www.NCTSN.org) is a valuable resource for parents, educators, school officials, behavioral health personnel, legislators and interested citizens to enhance knowledge of childhood trauma. Topics on its website include *Terrorism and Disasters*, *Psychological First Aid for Schools*, *The 12 Core Concepts for Understanding Traumatic Stress Responses in Children and Families*, *Understanding Childhood Traumatic Stress* and *Resources in Response to the Recent Shooting.*

The following ten points are from *Talking to Children about the Shooting** one of the resources available on the NCTSN website under the *Resources in Response to the Recent Shooting*:

• ***Start the conversation.*** Talk about the shooting with your child; not talking about it can make the event even more threatening in your child's mind.

• ***Ask what already has been heard about the events from the media and from friends.*** Listen carefully and try to figure out what he or she knows or believes. Listen for misinformation, misconceptions, and underlying fears or concerns.

• ***Gently correct inaccurate information.*** If your child/teen has inaccurate information or misconceptions, take time to provide the correct information in simple, clear, age-appropriate language.

• ***Encourage your child to ask questions and then answer those questions directly.*** A child/teen may have some difficult questions about the incident: For example, she may ask if it is possible that it could happen at her school; she is probably really asking whether it is "likely." Concern about re-occurrence will be an issue for parents and children/teens alike. While it is important to discuss the likelihood of this risk, a child is also asking if she is safe. This may be a time to review plans your family has for keeping safe in the event of *any* crisis situation. Provide any information you have on the help and support the victims and their families are receiving. Having question-and-answer talks gives your child ongoing support as he or she begins to cope with the range of emotions stirred up by this tragedy.

• ***Limit media exposure.*** Limit your young child's exposure to media images and sounds of the shooting and *do not allow your very young children to see or hear any TV/radio shooting-related messages*. Even if they appear to be engrossed in play, children often are aware of what you are watching on TV or listening to on the radio. What may not be upsetting to an adult may be very upsetting and confusing for a child. Limit your own exposure as well. Adults may become more distressed with nonstop exposure to media coverage of this shooting.

• ***Common reactions.*** Children/teens in the immediate aftermath of the shooting, may have more problems paying attention and concentrating. They may become more irritable or defiant. Children and even teens may have trouble separating from parents, wanting to stay at home or close by them. It is common for young people to feel anxious about what has happened, what may happen in the future, and how it will impact their lives. Sleep and appetite routines may change. In general, these reactions lessen within a few weeks.

• ***Be a positive role model.*** Consider sharing your feelings about the shooting with your child/teen, but at a level they can understand. You may express sadness and empathy for the victims and their families. You may share some worry, but it is important to also share ideas for coping with difficult situations like this tragedy. When you speak of the quick response by law enforcement and medical personnel to help the victims, you help your child/teen see that there can be good, even in the midst of such a horrific event.

• **Be *patient.*** In times of stress, children/teens may have trouble with their behavior, concentration, and attention. While they may not openly ask for your guidance or support, they will want it. Both children and teens will need a little extra patience, care and love.

• ***Extra help.*** Should reactions continue or at any point interfere with your children's/teens' abilities to function or if you are worried, contact local mental health professionals who have expertise in trauma. Contact your family physician, pediatrician, or state mental health associations for referrals to such experts.

Visit the National Child Traumatic Stress Network website to review the above points and to learn more about childhood trauma.*http://www.nctsn.org/sites/default/files/assets/pdfs/talking_to_children_about_the_shooting.pdf

Submitted by Steve Bistran

TOBACCO: THE OVERLOOKED ADDICTION

Every year tobacco causes more deaths than AIDS, alcohol abuse, automobile accidents, illegal drugs, fires, homicide and suicide *combined*. Tobacco related diseases are the cause of death for approximately 440,000 people in the United States annually. People recovering from mental illness and/or substance abuse smoke at rates several times that of the overall population; yet providers of mental health and addiction services often overlook and fail to treat tobacco addiction. There are many reasons for this including beliefs that 1) other addictions are more important and need to be addressed first, 2) quitting tobacco interferes with recovering from alcohol and other substance addictions, 3) tobacco use is not truly an addiction, 4) tobacco is the only pleasure some people have in their lives, 5) consequences of tobacco use are exaggerated and 6) people don't really want to quit tobacco.

And yet, cigarette smoking has been identified as the most important source of preventable morbidity and premature mortality in the United States and the world. The Centers for Disease Control's list of the World's Most Addictive Substances *places tobacco at the top.* Heroin placed 5th. Nicotine from a cigarette reaches the brain in 8 seconds… which is faster than the time it takes for injected heroin or cocaine to reach the brain...about 12 seconds. Cigarette smoke contains over 4,800 chemicals; 69 of which are known to cause cancer; some of the chemicals include acetone, carbon monoxide, formaldehyde, hydrogen cyanide, lead, ammonia and cadmium.

Nationally, males have significantly higher rates of smoking prevalence (23.1%) than females (18.3%). In Connecticut the rates are approximately 16.6% for men and 14.5% for women.

How do people with trauma histories, trauma exposure and/or PTSD fare when it comes to tobacco addiction?

Multiple studies indicate both lifetime and current smoking rates are significantly higher among persons with either a lifetime history of or current PTSD *compared to* persons without these psychological characteristics. This pattern holds for both adults and youth across genders. On average, it appears that in the U.S. approximately 45% of persons with current PTSD are heavy smokers with over 70% smoking more than 20 cigarettes per day compared to the general population smoking rate of approximately 22%.

Prospective studies of the relation between trauma exposure and smoking suggests that exposure to a traumatic event is associated with increased smoking behavior, including smoking status, smoking level, and nicotine dependence.

Smoking rates tend to be higher for those individuals who have experienced "more severe" forms of trauma exposure. Among adults, current smoking rates of traumatic event-exposed adults range between 32% (intimate partner physical domestic violence) to 58% (severe battering); among adolescents these rates vary from 13% (boys witnessing violence) to 36% (physical abuse).

Individuals recovering from substance use other than tobacco as well as trauma are likely to have even higher rates of tobacco use (70% to 90%). To ignore tobacco use among people recovering from trauma is to not fully assist them in their recovery. Enhancing physical health is crucial in assisting individuals to manage the effects of trauma. Surveys indicate the majority (typically 60% to 70%) of tobacco users would like to quit and they need to be assisted to do so.

All providers of services to people in recovery from personal trauma, exposure to traumatic events and PTSD should ASK every client about tobacco use and if the answer is affirmative, ADVISE each client of the importance of quitting tobacco use to assist current and future recovery. Clients interested in quitting should be referred to either an "in-house" or local tobacco addiction treatment provider to develop a "quit plan" and set a "quit date." Clients uninterested in quitting are often helped within a "motivational interviewing" context that emphasizes physical health as a means of achieving overall recovery from trauma. The goal in the latter instance is to motivate tobacco users to want to quit and to begin planning the process.

For an excellent overview of this topic, see Feldner, Matthew T., Babson, Kimberly A., and Zvolensky, Michael J. Smoking, Traumatic Event Exposure, and Posttraumatic Stress: A Critical Review of the Empirical Literature. Clinical Psychology Review, January, 27(1), 2007, Pages 14–45. Read and/or download: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2575106/ Consult The Clinical Practice Guideline Treating Tobacco Use and Dependence: 2008 Update published by the U.S. Department of Health and Human Services for the most current recommended practices to deliver effective smoking cessation supports and interventions. To get free copy call: 1-800-311-3435 or download: http://www.ncbi.nlm.nih.gov/books/NBK63952/For a comprehensive overview of motivational interviewing practices see Treatment Improvement Protocol (TIP) 35: Enhancing Motivation for Change in Substance

Abuse Treatment.or download at http://ncadi.samhsa.gov/govpubs/BKD342/ or to order up to 10 free copies, phone: 1-800-729-6686

Submitted by Steve Bistran

My Ongoing Recovery Journey

Radical acceptance is letting go of fighting reality. The term "radical" means to imply that acceptance has to come from deep within and has to be complete. Acceptance is the only way out of hell. It is the way to turn suffering that cannot be tolerated into pain that can be tolerated. Pain is part of living; it can be emotional and it can be physical. Pain is nature's way of signaling that something is wrong, or that something needs to be done. (taken from DBT by Marsha M. Linehan, Ph.D.)

Born 4 pounds 11 ounces. Almost died. Developed pneumonia of the right lung. Stayed in the hospital for a month. They wanted me to gain weight, YIKES!!! I come from a past of physical, verbal, emotional abuse from an authority figure, a rape at 17 years old, several bad relationships and two failed marriages. Two suicide attempts led me to ICU, alcohol and drugs for 3 years, then with therapy, AA and NA, I became clean and sober for a year, had another relationship that produced a child, became a single parent for 8 years (no drugs or drinking) experienced two trips to the psych ward, remarried for love, had several more trips to the psych ward and after 17 years my marriage ended. Throughout my life I've had numerous surgeries to my body, so I also have many physical challenges.

Whatever challenges I went through in the past do not define me. They afford strength within me, which is dormant until I activate it from within. The reality is I know that this is true. I found that the ability to endure the bad past is strength to overcome whatever comes before my path in the present and future.

Change and being proactive in life is significantly the key to one's recovery journey. How I make the changes in my life is to be willing to do the changes I need on a continuing basis. Proactive is action. If I act on my own behalf I become more confident in my own gifts and abilities within myself. Like flipping a switch. (Not so easy, I know).Once I make a decision to do something I'm inclined to do it. I believe I have the strength and fortitude to be positively proactive in what I allow to happen in my recovery journey. It's so easy to do the negative things in life. Being pro-active is being determined to reverse the old habits in life. To bring oneself out of chaos takes courage that lies within us, courage that is dormant until we activate it. Being proactive means using skills and tools that are positively and carefully thought out and taught to us.

In DBT, TARGET 26 for Women, Next Steps (which includes process painting), and other classes from WCMHN-Torrington area, I've learned that not all skills will work for me, but they are all taught to me so that I can have the courage to use the ones that are useful to me on a continual basis and draw on them as I need them. I thank God, my higher power, for my faith in him, my family's love and support and for the staff and peers at WCMHN-Torrington Area (the skills, tools, and support), Charlotte Hungerford Hospital's 7th floor (tools), Partial Hospital Program, (skills, tools and medication management), Behavioral Health Center (medication management), for the staff and peers at Prime Time House in Torrington (for support), and for all I have learned and continue to learn in my ongoing and proactive recovery journey!

Yours in Recovery, Jackie Sandy

UPCOMING 2013 Behavioral Health Conferences and Lecture Series

Ninth Annual Childhood Grief and Traumatic Loss Conference March 19th, Pasadena California manetla@dcfs.lacounty.gov

National Council for Behavioral Health Conference, 2013, April 8th -10th, Las Vegas www.2013mentalhealthconference.com

28th Annual NASW/CT Statewide Conference April 19, 2013, Coco Key, Waterbury, CT wwwnaswct.org

24th Annual International Trauma Conference May 29th - June 1st, Justice Resource Institute, Boston, MA www.traumacenter.org

2013 EMDRIA Conference, September 26th-29th, Austin, TX www.emdria.org

SAVE THE DATE: Healing the Generations Conference: October 2nd - 4th. Sponsored by Clifford Beers with additional support from DMHAS and the CT Women's Consortium.

Monthly Free Lecture Series with Bessel van der Kolk, M.D. The Trauma Center at the Justice Resource Institute offers a free monthly lecture series for mental health professionals. Lectures are held from 12 -1:15PM on the first Thursday of each month at The Trauma Center:1269 Beacon Street, Brookline, MA.

Tips for Staff Care

As I write this we are about seven weeks out from the Sandy Hook shooting and many have contributed to the healing by spending an hour, a day, or weeks supporting those who are in shock, grieving, angry and anxious.

On December 14 as the first crisis response counselors were ready to be deployed to Newtown, an NPR reporter asked one of the counselors - "What do you do? What do you say?" She replied, "First I call my own support system, then I make sure I eat and am hydrated, I pack water and a snack. The team comes together and we process our own feelings and when we are "right", we go". I don't know her name, but her message of attending to herself first, even in the face of terrible ragedy, resonated with me and has not left me.

I recently read an article in the January 2013 issue of *Counseling Today* entitled "Who's taking care of superman?" Once I got past the exclusion of superwoman in the title, I saw the lead sentence "Counselors need to reframe self-care not as a selfish act but rather as a valuable and necessary step in providing proper care to others" (Shallcross, 2013). The article goes on to say that self-care is not something we can do alone; we need support and reminders from others, namely our co-workers.

We are early in the new year - I challenge you to make this the year of self-care.

Submitted by Eileen M. Russo

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

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