TRAUMA MATTERS

Volume 11 Issue 4 Spring 2013

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

INSIDE THIS ISSUE:

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

Mental Health First Aid - A National Conversation

Shame, guilt, blame, and weakness, all words associated with mental illness, one of the last social stigmas that developed society is burdened with. The fallout from this prejudice has immeasurable costs to both the nation and those who suffer from behavioral health issues.

Today the national conversation on mental illness that began fifty years ago, when President Kennedy signed the country's first mental health legislation, is moving towards a Malcolm Gladwell tipping point: "That magic moment when an idea, trend, or social behavior crosses a threshold, tips, and spreads like wildfire" (Gladwell, 2000). Recent violent tragedies across the country have people in disbelief, and communities looking for solutions in gun control legislation and funding for mental health services. In January, President Obama elevated the dialogue by calling for stricter gun legislation and greater funding for mental health; especially for young adults, aged 16-25, with emerging mental health issues. A large part of Obama's initiative, if enacted, will fund Mental Health First Aid (MHFA), a public education training that originated in Australia in 2000 and was introduced in the United States in 2008.

At the recent 2013 National Behavioral Health Council Meeting in Las Vegas, Nevada, keynote speaker Health and Human Services Secretary, Kathleen Sebelius, along with other presenters, echoed the irony that we treat broken bodies but not broken minds. People don't just break physically; they also break mentally. The science of the brain over the last several decades has increasingly evidenced what mental health providers already have conjectured: that much of what is manifested in behavioral dysfunction is influenced by brain dysfunction.

Cultural shifts occur slowly through small incremental changes. In order for us to eventually change outcomes, we must collectively acknowledge that something is broken. We desperately need to become a nation that is as educated on mental health, and comfortable talking about mental illness, as we are about discussing diabetes, heart disease and cancer. Just imagine if MHFA training was as common place and highly recommended in saving lives as CPR training.

Recent events in Newtown, Connecticut and Boston, Massachusetts, have forced us to do just that. MHFA is being endorsed in cities, towns and states as the most credible intervention in educating the larger non-clinical public on what mental illness looks like and how to handle it when you see it. Feedback from participants evidences that MHFA eliminates fear associated with mental illness. We know that when we replace fear with knowledge, we can begin to eliminate stereotypes that result in stigmatization. Most significantly, we can help build the necessary social acceptance between the public and those isolated in their mental health struggles.

So what does the MHFA curriculum teach? The updated, soon-to-be-released, 8-hour version of the original 12-hour course, teaches how to: recognize the signs and symptoms of mental illness and addiction disorders (depression, anxiety,

psychosis, eating), de-escalate a crisis situation safely, use first aid for children and adults affected by traumatic events, and understand and respond appropriately to individuals with suicidal thoughts and behaviors.

The MHFA curriculum frames each learning module with a generalized action plan under the acronym ALGEE; assess for risk, listen non-judgmentally, give reassurance and information; encourage professional help, self-help, and other support strategies. This year, the originators of MHFA have rolled out a new curriculum specifically targeted for youth in relation to family support.

The MHFA movement is growing daily. The US currently has 2,500 MHFA instructors and over 100,000 trained community members. These individuals are ambassadors in demystifying mental health by teaching people that the vast majority of individuals with mental illness are not violent, are often isolated in their illness and can improve their functioning and quality of life with appropriate help.

Connecticut, along with a growing number of concerned states, is already finding ways to bring MHFA education to cititzens. On May 17th, Governor Dannel P. Malloy announced a collaboration between DMHAS, Hartford's Institute of Living and Hartford Healthcare Behavioral Health Network to fund a 5-day MHFA instructor training program for 30 individuals that will help educate school districts and communities statewide. DMHAS Commissioner Pat Rehmer commented on the joint agency effort: "We have a long standing history together and now continue our partnership with MHFA. It is particulary timely that we can announce these new efforts since May is Mental Health Awareness Month".http://www.governor.ct.gov/malloy/cwp/view.asp?a=4010&Q=524934.

On a national legislative level, MHFA has a champion. House of Representative Ron Barber (D-AZ), having served as former district director for Congresswoman Gabrielle Giffords, introduced legislation, House Bill 274 (2013), which would authorize $20 million in grants to train emergency personnel, police, teachers, students and the general public in fiscal year 2014. Eventual passage of HR 274 is dependent on a complexity of factors that can be influenced by the collective mental health community grassroots support and advocacy of all of us.

The conversation to "change business" as usual in our approach to mental health has infiltrated a broad array of political, socioeconomic and cultural worlds. MHFA has the potential to help the public find a common language to understand mental illness, empathize with those who have it, and collaborate to create a new holistic integrated paradigm of health.

Submitted by Aili Arisco

For more information about Mental Health First Aid and how you can join the conversation visit:
http://www.mentalhealthfirstaid.org/cs/

A GOOD NIGHT'S SLEEP - PAVING THE WAY TO RECOVERY

This article is the third in a series focusing on recovering and maintaining physical health. For the person recovering from trauma this series offers some basic strategies for enhancing physical well-being. For the service provider, this series offers health-focused discussion topics for working with individuals recovering from trauma. In all instances, a physician should be consulted before making lifestyle changes that may affect health outcomes.

A person in recovery from both behavioral and substance difficulties confided that her path to recovery did not truly get onto the fast track until she had stabilized her sleep patterns and obtained sufficient amounts of sleep as advised by her counselor. The importance of sleep in fostering recovery and maintaining health is often given lip service, but not often addressed with people in recovery.

For individuals coping with trauma and PTSD, sleep disorders are one of the most commonly reported symptoms and may require treatment by a qualified sleep specialist. Men and women who have experienced childhood and adult trauma, along with returning veterans of war and first responders to disasters and tragedies across the nation, regularly experience a change in sleep patterns.

Sleep patterns of trauma sufferers are often characterized by fitful sleeping and patterns of difficulty remaining asleep all night. Nightmares are also very common among trauma sufferers. Fear of nightmares, along with the entire range of sleep problems experienced by trauma sufferers, creates additional pre-sleep anxiety and concerns about going to sleep. Worries or thoughts of the traumatic event may begin as soon as they go to bed.

Current recommendations for number of hours of sleep for adults is from 7 or 7.5 to 9 or 9.5 hours of sound sleep nightly according to the Mayo Clinic, National Sleep Foundation, Centers for Disease Control and Prevention, and National Institutes of Health.

There is now an established and ever-growing body of research documenting the effects of sleep deprivation. Some of these effects include: 1) lower stress threshold; 2) impaired memory; 3) trouble concentrating; 4) decreased optimism and sociability; 5) impaired creativity and innovation; 6) increased resting blood pressure; 7) increased food consumption and appetite; and 8) increased risk of cardiac morbidity.

The good news is that sleep disorders are treatable, often with minimal intervention and may not require medication. Treatments for persistent and disruptive sleep disorders are very specific, so it is important to seek treatment from a qualified sleep specialist.

Steps to Ensure Sufficient Sleep

Lawrence Epstein, M.D., Chief Medical Officer of Sleep Health Centers, Instructor in Medicine at Harvard University and co-author of The Harvard Medical School Guide to a Good Night's Sleep along with Sleep Specialist Stephanie Silberman, Ph.D. suggest the following to ensure sufficient sleep:

---

1. **Realize sleep is essential** to healthy living and that all too often sleep is the first thing that gets sacrificed if we are pressed for time.

2. **Have a regular sleep schedul**e by getting up and going to bed at approximately the same times.

3. **Create a pre-sleep ritual** to establish a clear association between certain activities, (e.g., reading, a warm bath, soothing music, relaxing exercise) and sleep, so that your body recognizes it is time to slow down.

4. **Write down your worries** earlier in the day and what to do about them. If a worrying thought comes up right before bed, mentally check it off," and either say to yourself "I've dealt with that," or "I'm dealing with it" which usually helps to create a sense of relief.

5. **Use bed for sleep and intimacy only.** If you are having trouble sleeping, do not read, watch TV, use a computer, phone or text in your bed as these activities stimulate the brain, instead of relaxing it.

6. **Create an optimal sleep environmen**t by keeping the room dark, quiet and at a moderate temperature to enhance relaxation.

7. **Busy your brain with mental exercises** that can distract from worries. Simply focusing on the details of an object's, color, shape, size and function or the lyrics of a favorite song can help ready the brain for sleep.

8. **Focus on positive memorie**s and thoughts when you find yourself lying in bed worrying.

9 .**Practice deep breathing and relaxation exercises**, especially progressive muscle relaxation, to reduce anxiety and racing thoughts.

10**. Physical activity is a major anxiety reducer** if practiced at least several hours before bedtime to avoid overstimulation.

11. **Avoid caffeine and alcohol consumption,** the biggest saboteurs of sleep. Certain medications can also disturb sleep so talk to your prescribing physician about taking medication(s) at a different time or taking different medicine(s) altogether.

Sleep Resources

http://psychcentral.com/lib/2011/12-ways-to-shut-off-your-brain-before-bedtime/
http://www.helpguide.org/life/sleep_tips.htm
The Insomnia Workbook: A Comprehensive Guide to Getting the Sleep You Need by Stephanie Silberman, Ph.D. Oakland, CA: New Harbinger Publications, 2009 http://www.sleeppsychology.com/sleep-disorder-insomnia-books.html

The ACE Score: *Measuring Exposure to Adverse Childhood Events*

In the field of mental health, the negative impact of early childhood abuse and neglect has been increasingly recognized as a factor in the development and severity of mental illnesses. Over the past 20 years, the developmental impact that starts in childhood from sexual and physical abuse, neglect, psychological abuse, and the resulting problems in attachment, have been repeatedly documented. (Cole & Putnam, 1992; Perry et al;1996; Shore, 2001)

The ACE study represents research by Dr. Vincent Felitti and Dr. Robert Anda that evidences the influence of childhood experiences not just on mental health, but physical health as well. Mind and body are developmentally inseparable; damage to the mind or the body, especially damage inflicted by caretakers to children, results in long-term negative medical and psychiatric outcomes (Frewen & Lanius, 2006).

In 1985, Dr. Vincent Felitti, a cardiologist at Kaiser Permanente's Department of Preventive Medicine, was reviewing the results of a program he had established in collaboration with the Centers for Disease Control and Prevention(CDC), to help obese adults lose weight (ACE Reporter, 2003). He was astonished to observe that the people who had been most successful at losing weight in his program most frequently dropped out. Dr. Felitti reviewed the histories of 286 participants, and found that many of them had histories of sexual or physical abuse. This led Dr. Felitti to wonder about the way that obesity might function as a solution for adults whose traumatic histories led them to want to avoid physical or sexual contact. Further research by Felitti and Anda, (2010), identified a set of ten adverse childhood experiences (ACES) that were consistently related to adverse physical and psychological health outcomes. The more ACE factors a person experienced in childhood, the worse the health outcome. The *"ACE score"* is obtained by a simple count of the types of adverse experiences a person had, rather than the number of times a type of adverse experience happened.

Felitti and Anda, (1998), recognized that individuals who have ongoing psychological distress as a consequence of early trauma, often engaged in self-medicating behaviors to reduce distress. These behaviors decreased psychological distress in the short term, while contributing to negative health outcomes in the long term. The findings of the ACE studies crossed socioeconomic boundaries: regardless of class or ethnic group, people exposed to multiple different stressors had more negative health outcomes. Gender however, was a significant factor in ACE score outcomes; "…women were 50% more likely than men to have experienced five or more categories of adverse childhood experiences." (Felitti & Anda, 2010, p. 77). Appreciation of the significance of ACE experiences could be of enormous benefit within both the mental health and physical health systems. Agencies would do well to include assessment of ACE experiences as part of their usual intake process. With this knowledge many physical and psychiatric illnesses can be more adequately treated.

Submitted by Ellen Nasper

For a complete list of references for this article please visit: http://www.womensconsortium.org/References_Trauma_Matters.cfm

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often…**

Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often or very often…**

Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever…**

Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

Yes No If yes enter 1 _____

4. Did you **often or very often** feel that …

No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you **often or very often** feel that …

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No If yes enter 1 _____

6. Were your parents ever separated or divorced?

Yes No If yes enter 1 _____

7. Was your mother or stepmother: **Often or very often** pushed, grabbed, slapped, or had something thrown at her?or Sometimes, **often, or very often** kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

Now add up your "Yes" answers: ____

This is your ACE Score: "As your ACE score increases, so does the risk of disease, social and emotional problems. With an ACE score of 4 or more, things start getting serious. The likelihood of chronic pulmonary lung disease increases 390 percent; hepatitis, 240 percent; depression 460 percent; suicide, 1,220 percent". http://acestoohigh.com/got-your-ace-score/

The Road Less Traveled:
The Role of the Female Therapist in a Men's Trauma Recovery Group.

For the past year I had the privilege of co-facilitating two men's trauma recovery and empowerment groups, at a state-operated clinic in Waterbury, Connecticut. For several years prior I had been seeing a number of men in individual therapy and noticed a frustrating trend: the prevalence of men who presented with mental health problems, substance abuse and marginalization while also struggling with chronic terror, pain, shame, fear and horror related to early exposure to physical, sexual and emotional abuse. Coupled with this, I found that many of the substance abuse programs I was referring clients to were not trauma sensitive, and tended to feed into the men's feelings of anger and underlying victimization. I also discovered that despite the availability of trauma-survivor groups for women, I could find no active groups for men.

In search of a solution, I attended several trauma-informed workshops addressing men's issues, including Roger Fallot's Men's Trauma Recovery and Empowerment Model (M-TREM), intensive workshops by John Brier on the Integrative Treatment of Complex Trauma (ITCT), and Donald Meichenbaum's Trauma-focused Cognitive Behavioral Therapy (CBT). Anxious to implement what I had learned, I inquired about co-facilitating a group with a male therapist and eventually was introduced to Doug Conroy, LCSW, who had several years of experience with M-TREM. In the midst of the excitement of finally having this resource come to life, we both paused for a moment and asked the question: "Because of the explicit nature of the individuals' trauma histories, would it matter if a woman were the co-facilitator?" Although the premise of the group is predicated on abuse in the context of the continued influence on the individual's life, versus exploring details of the survivors' personal trauma histories, we wondered if the presence of a female would inhibit the process, particularly for those men who were victimized by women. After grappling with these questions, we decided that we would begin with an informational session and that Doug would later pose the question to the men during the screening process. If there was overwhelming negative response to a female co-facilitator, Doug would seek a male counterpart.

Prospective members made comments such as, "It really doesn't matter to me as long as she is an experienced group leader", or "I'm just looking forward to learning how to talk about these problems and become a better person." So with the blessing of the members, we began the 24-week group. The well-researched structure of the M-TREM format lent itself to addressing gender role expectation as it relates to responses to trauma through first identifying male myths. The M-TREM structure allowed me to tap into my skills as a strategic therapist by identifying and challenging these male myths, then providing alternate tools of communication.

As the group progressed, we noticed how the six to eight members, from different environments and eras, provided spontaneous support to each other. Initially, the men would apologize if they swore or "talked trash" about others in front of me. We were able to address their language as unexpressed feelings of anger that were important to voice because they had led to unhealthy and dangerous relationships. We also identified how related myths such as "men protect their women and children" could create a burden and force men to close off their feelings. The men became more and more curious about my perspective on various issues that came up during the discussions and appreciated my input as a woman. Through frank dialogues about how trauma and violence shape responses and behaviors it became clear that the gender of the co-facilitator was not an influential or negative factor for group members, but rather other criteria were more significant. This was evidenced at week six when Doug's schedule prevented him from co-facilitating a session. We arranged for a very skilled male substitute. The participants voiced their concern that having a different co-leader was too disruptive because they "weren't sure they could trust him." In the event of future absences, they preferred to meet with one therapist because "Joan and Doug both know who they are."

In the end, it was clear to both of us, that the therapeutic success in a group is measured by the leaders' ability to provide a safe, non-judgmental environment that encourages positive interaction towards a mutual goal regardless of the gender of the therapist.

"Two roads diverged in a wood, and I, I took the one less traveled by, and that has made all the difference." *Robert Frost*

Submitted by Joan Pavlinsky, LCSW

Book Review

Trauma Stewardship; An Everyday Guide to Caring for Self While Caring for Others

By Laura van Dernoot Lipsky with Connie Burk

Stewardship is defined by the Merriam -Webster dictionary as the "careful and responsible management of something entrusted to one's care." The authors of *Trauma Stewardship* conveys that we, as providers, are entrusted with the lived traumatic experiences of those who seek help, support and guidance. It then follows that if we are to be responsible in care giving, we need to care for ourselves.

Trauma Stewardship describes 16 warning signs of the trauma response in those providing assistance such as numbness, grandiosity and hopelessness. What is different about this book is that the authors include profiles of those who have been impacted by their work. The profiles include an Attorney General, a biology professor, an outreach worker and others who are often forgotten in discussions of vicarious trauma. Author van Dernoot Lipsky (2007) outlines a plan toward stewardship that is an inside-out journey of personal exploration. For example, one of the exercises recommended is taking a moment before you begin your day to ask "Why am I doing what I am doing?" Listen for the answer, remind yourself of the choice you are making and breathe. There are mindfulness exercises, cartoons (my favorite one is labeled "zerotasking"), and inspirational quotations. One of these is by Howard Thurman, an American theologian and civil rights leader:

"Don't ask yourself what the world needs. Ask yourself what makes you come alive. And go do that. Because the world needs people who've come alive." (van Dernoot Lipsky, 2007, p. 244)

Are you doing what makes you come alive? If the answer is yes, are you caring for your passion?

Submitted by: Eileen M. Russo

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

Nonprofit Organization
U.S. Postage Paid
New Haven, CT
Permit No. 118

dmhas