MENTAL HEALTH NEWS™

YOUR NEW SOURCE OF INFORMATION, EDUCATION, AND ADVOCACY

FALL 2001 SERVING THE MENTAL HEALTH COMMUNITY VOL. 3 NO. 3

Understanding and Treating

Posttraumatic Stress Disorders

Mental Health News is honored to present our readers with an interview with one of the nations leading experts on Posttraumatic Stress Disorders (PTSD), Dr. Randall Marshall. Dr. Marshall is Associate Professor of Clinical Psychiatry and Director of Trauma Studies at the Anxiety Disorders Clinic, New York State Psychiatric Institute, Columbia University College of Physicians and Surgeons—America's oldest psychiatric research institution.

Mental Health News wishes to thank Dr. Marshall for helping us understand the nature and treatment of Posttraumatic Stress Disorders.

Q: You were recently quoted at the APA convention in Atlanta as to the scope of suffering and disability due to symptoms of PTSD here in the United States.

A: Yes, Nearly eight percent of individuals in the U.S. -- 20 million people -- will have full-blown PTSD in their lifetime, and as many as 20 million more people may suffer from disability and distress related to PTSD symptoms even though they do not have the full disorder. The tragedy is that many of these people do not get the help they need because the problem is not identified and they don't receive appropriate treatment."

Randall Marshall, M.D.

Q: When was posttraumatic stress disorder first described in literature?

A: Going back centuries, PTSD had been recognized in both medical and literary writings, but it was only recently officially recognized in the DSM III as Posttraumatic Stress Disorder in 1980. Before that it was often referred to in descriptions of war trauma, but also there's a quite interesting 19th century literature in relation to accidents. For example, there was something-called *railway spine syndrome*, which was thought (much like shell shock) to be a neurological disorder caused by the impact of the many cataclysmic train wrecks of the time.

What the DSM does is identify core features. This was a critical advance in the field, but it is important to realize that PTSD as a clinical syndrome is much broader. Comorbidity, based on DSM assessments, is extremely high. The DSM breaks down the description of PTSD into Diagnostic Features and Associated Features, but clinically it isn't as important to separate the two, as all clinical issues need to be addressed. Problems with depression, aggressive outbursts, relationships, and substance abuse are very common.

PTSD by definition is a triad of symptom clusters that are known to go together. They can be summarized as re-experiencing the trauma in the form of dreams or unbidden images or perhaps just frequent thoughts about the trauma. Flashbacks are rarer, and are a kind of dissociative re-experiencing.

The second cluster is *avoidance* and *emotional numbing*.

Avoidance can be both internal and external. The individual tries to avoid thinking about the trauma by pushing thoughts out of his or her mind. But the patient might also avoid situations, which are reminders of the trauma. The emotional numbing I refer to specifically describes numbing of positive emotion. So it's not just feeling nothing at all. With PTSD numbing, people mostly feel negative affect like anxiety, fear, depression and rage—but lose the capacity for feelings of love or tenderness or pleasure.

Q: Is emotional numbing an automatic response or are people in this situation struggling to consciously block these upsetting feelings and recollections of the trauma they experienced?

A: That's a very important question. Some formulations would say that it's a defense, that it's a shutting down of all emotions because they become overwhelming—but I think that there is reason to think that in some cases it may be a direct consequence of the disorder—something like a burnout of normal emotional capacity because of the overwhelming dominance of fear and anxiety.

see *Marshall Interview* page 16

Inside This Issue Of MENTAL HEALTH NEWS

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MENTAL HEALTH NEWS™

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The Editor's Desk

FINALLY... AN ATLAS OF DEPRESSION

By Ira Minot, Editor-Publisher Mental Health News

Depression is the flaw in love. To be creatures who love, we must be creatures who can despair at what we lose, and depression is the mechanism of that despair.

These are the first words of Andrew Solomon's incredible new book ***The Noonday Demon: An Atlas of Depression*** (Scribner).

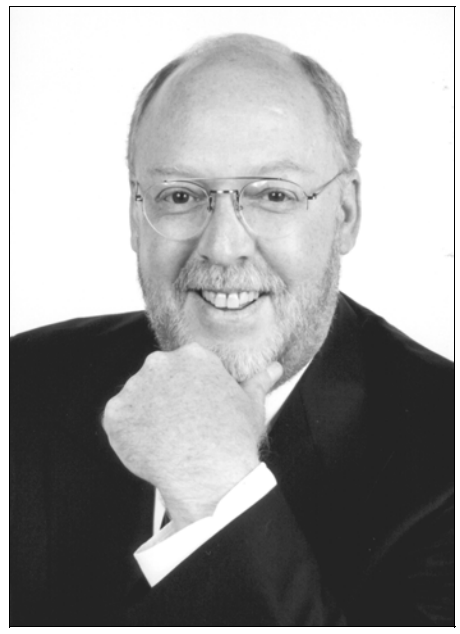
Solomon, a novelist and Contributing Writer for *The New York Times Magazine*, gives us an intimate and articulate look at the human, scientific, and political aspects of depression which was inspired by his own journey through the harsh an unfathomable depths of depression.

I had the good fortune to meet Andrew at his home in New York. I wanted to introduce *Mental Health News* readers and the entire mental health community to this valuable new resource, which is sure to become required reading for individuals and families whose lives have been touched by the illness of depression.

I learned, in his own words, why Andrew Solomon wrote *The Noonday Demon: An Atlas of Depression.*

"When I was recovering from my first breakdown, I read everything on the subject and felt that the book I needed wasn't there. Most of the books that were there fell into one of three categories. There were first-person narratives that were moving and so anecdotal as to be largely irrelevant to anyone else; or they were medical texts that were very dry and highly abstract; or they were written in the patronizing abstract of self-help. There was nothing synthetic, nothing sweeping, nothing in which I could recognize myself and learn what I needed to know. So I decided to write an atlas of depression—to map the illness in its entirety and try to convey every insight that can be deduced from our current state of knowledge."

I asked Andrew what advice he would give to the family member or friend of someone suffering from depression?



Ira Minot

"Depression is a disease of loneliness, and the best thing you can do is to mitigate the isolation of a depressed person. No matter how withdrawn that person is, it is helpful to him to have constant concrete manifestations of support around him. It is important to remember that the depressive's belief in the intractability of his condition is one of the symptoms of the illness. Keep reminding the person who suffers that the situation is temporary, that things *will* change, and that the voices he hears within himself are the voices of depression and not the voice of reason. Encourage your depressed friend to seek the professional help he may need—to find medications if appropriate (and they usually are) and to find some form of talking therapy to enable the emergence from despondency. Give encouragement. Don't, however, keep telling the person to cheer up, or remind the person in great detail of how wonderful his life is. Don't be patronizing. Accept that the statements being made by the depressive, no matter how distorted they may seem, are *his* truth. Have some respect for the reach of the illness."

I wish to salute Andrew Solomon for bringing this wonderful work to readers from all disciplines and walks of life who should (and must) understand the struggle we pursue in raising consciousness, crying for just legislation, and in striving to eliminate the wrath of social stigma towards mental illness.

Letters To The Editor

Involuntary Outpatient Commitment Denies Consumers Valuable Resources

By Joshua Koerner

The following is adapted from testimony before a public hearing on The New York State Office of Mental Health's Statewide Comprehensive Plan for Mental Health Services: 2001-2005.

Westchester County is a leader in the establishment of a Single Point of Entry (SPOE) system. In a Single Point of Entry all referrals for a given service are coordinated so that instead of having to submit six applications to six providers, one application is reviewed by many providers simultaneously. I have worked with housing providers on the Single Point of Entry Housing Committee since it was formed over two years ago. It is from this unique vantage point that I have had the opportunity to observe the consequences of Kendra's Law, also known as Assisted Outpatient Treatment (AOT). In reality it is Involuntary Outpatient Commitment.

Look what happens when AOT meets SPOE. Westchester County is in a housing crisis. Years of conversion to co-ops and condominiums have left fewer and fewer rental units. Most new construction is of luxury housing. In New Rochelle, for example, some recently constructed studio apartments rent for more than $1200 a month. Existing section 8 housing is shrinking rapidly as fewer and fewer landlords are willing to renew section 8 contracts.

This in turn has led to a backlog of people in supported housing who have received section 8 certificates but have no place to use them, slowing the availability of supported slots. People accepted for new supported housing routinely require months to find an apartment.

CHOICE, a provider of peer advocacy, peer case management and peer outreach services, worked with a man I'll call "Michael" for many months. Michael was in the shelter system awaiting a housing placement. Michael can be tangential and disorganized, but he's a wonderful loving person and we are all very fond of him. Unfortunately there was a period during which his health deteriorated and he was victimized.

We worked with Michael, his condition improved, we assisted him in making an application for supportive housing, and the Single Point of Entry committee accepted him pending an opening. Under normal circumstances a person like Michael, who was homeless, would be a top priority for housing. That's the whole point of having a Single Point of Entry. However, because of AOT this was not to be the case.

While Michael was awaiting that opening an individual I'll call Tom had an AOT petition brought against him, and he was moved to the top of the housing list. The slot in a treatment apartment that would have been Michael's went to Tom instead. It was as though Michael's adherence to treatment was now a point against him. Tom, who was actively using illicit drugs and showed little interest in treatment, was rewarded with a housing slot.

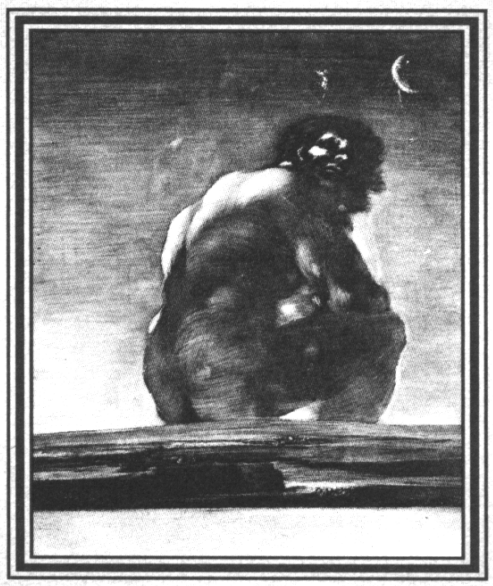
In the months since—Tom has spent only a few days in the apartment. He's been in and out of rehab and inpatient facilities. Meanwhile Michael's condition again deteriorated; and the window of opportunity during which he might have successfully engaged with community supports was lost. He was placed on an inpatient unit, where he deteriorated further, and was then involuntarily transferred to a state hospital. Fortunately, the staff there recognized that Michael should never have been transferred in the first place—and we look forward to his return. But he will again have to wait for the apartment he should have had months ago.

AOT results in the misallocation of precious limited resources such as housing and funding. AOT is about fear: fear in administrators, who have had liability thrust upon them, as well as consumers, who rightly view AOT as coercive, involuntary outpatient commitment.

From a perspective of risk reduction, it may have seemed reasonable to rush the AOT person directly into housing. But the

see *Involuntary* on page 12

The Noonday Demon



An Atlas *of* Depression

❁

Andrew Solomon

NEWSDESK: TOP STORIES

Recommendations For Media Coverage Of Suicide Announced

Staff Writer
Mental Health News

The American Foundation for Suicide Prevention, American Association of Suicidology and Annenberg Public Policy Center have announced the following recommendations for the media coverage of suicide. These new, unified recommendations were developed in collaboration with the Office of the Surgeon General, Centers for Disease Control and Prevention, National Institute of Mental Health, Substance Abuse and Mental Health Services Administration, World Health Organization, National Swedish Centre for Suicide Research and New Zealand Youth Suicide Prevention Strategy.

Reporting on Suicide:
Recommendations for the Media

Suicide Contagion is Real

Between 1984 and 1987, journalists in Vienna covered the deaths of individuals who jumped in front of trains in the subway system. The coverage was extensive and dramatic. In 1987, a campaign alerted reporters to the possible negative effects of such reporting, and suggested alternate strategies for coverage. In the first six months after the campaign began, subway suicides and non-fatal attempts dropped by more than eighty percent. The total number of suicides in Vienna declined as well.[1-2]

Research finds an increase in suicide by readers or viewers when:

- The number of stories about individual suicides increase[3,4]
- A particular death is reported at length or in many stories[3,5]
- The story of an individual death by-suicide is placed on the front page or at the beginning of a broadcast[3,4] The headlines about specific suicide deaths are dramatic[3] (A recent example: "Boy, 10, Kills Himself Over Poor Grades")

Recommendations

The media can play a powerful role in educating the public about suicide prevention. Stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. They can also highlight opportunities to prevent suicide. Media stories about individual deaths by suicide may be newsworthy and need to be covered, but they also have the potential to do harm. Implementation of recommendations for media coverage of suicide has been shown to decrease suicide rates.[1,2]

Certain ways of describing suicide in the news contribute to what behavioral scientists call "suicide contagion" or "copycat" suicides.[7,9]

Research suggests that inadvertently romanticizing suicide or idealizing those who take their own lives by portraying suicide as a heroic or romantic act may encourage others to identify with the victim.[6]

Exposure to suicide method through media reports can encourage vulnerable individuals to imitate it.[10] Clinicians believe the danger is even greater if there is a detailed description of the method. Research indicates that detailed descriptions or pictures of the location or site of a suicide encourage imitation.[1]

Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim.[6]

Suicide And Mental Illness
Did you know?

More than 90 percent of suicide victims have a significant psychiatric illness at the time of their death. These are often undiagnosed, untreated, or both. Mood disorders and substance abuse are the two most common.[11-15]

When both mood disorders and substance abuse are present, the risk for suicide is much greater, particularly for adolescents and young adults.[14,15]

Research has shown that when open aggression, anxiety or agitation is present in individuals who are depressed, the risk for suicide increases significantly.[16-18]

The cause of an individual suicide is invariably more complicated than a recent painful event such as the break-up of a relationship or the loss of a job. An individual suicide cannot be adequately explained as the understandable response to an individual's stressful occupation, or an individual's membership in a group encountering discrimination. Social conditions alone do not explain a suicide.[19-20] People who appear to become suicidal in response to such events, or in response to a physical illness, generally have significant underlying mental problems, though they may be well-hidden.[12]

Questions to ask:

Had the victim ever received treatment for depression or any other mental disorder?

Did the victim have a problem with substance abuse?

Angles to pursue:

Conveying that effective treatments for most of these conditions are available (but underutilized) may encourage those with such problems to seek help.

Acknowledging the deceased person's problems and struggles as well as the positive aspects of his/her life or character contributes to a more balanced picture.

Interviewing Surviving Relatives and Friends

Research shows that, during the period immediately after a death by suicide, grieving family members or friends have difficulty understanding what happened. Responses may be extreme, problems may be minimized, and motives may be complicated. [21]

Studies of suicide based on in-depth interviews with those close to the victim indicate that, in their first, shocked reaction, friends and family members may find a loved one's death by suicide inexplicable or they may deny that there were warning signs.[22,23] Accounts based on these initial reactions are often unreliable.

Angles to Pursue:

Thorough investigation generally reveals underlying problems unrecognized even by close friends and family members. Most victims do however give warning signs of their risk for suicide (see Resources).

Some informants are inclined to suggest that a particular individual, for instance a family member, a school, or a health service provider, in some way played a role in the victim's death by suicide. Thorough investigation almost always finds multiple causes for suicide and fails to corroborate a simple attribution of responsibility.

Concerns:

Dramatizing the impact of suicide through descriptions and pictures of grieving relatives, teachers or classmates or community expressions of grief may encourage potential victims to see suicide as a way of getting attention or as a form of retaliation against others.

Using adolescents on TV or in print media to tell the stories of their suicide attempts may be harmful to the adolescents themselves or may encourage other vulnerable young people to seek attention in this way.

Language

Referring to a "rise" in suicide rates is usually more accurate than calling such a rise an "epidemic," which implies a more dramatic and sudden increase than what we generally find in suicide rates.

Research has shown that the use in headlines of the word suicide or referring to the cause of death as self-inflicted increases the likelihood of contagion.[3]

Recommendations for language:

Whenever possible, it is preferable to avoid referring to suicide in the headline. Unless the suicide death took place in public, the cause of death should be reported in the body of the story and not in the headline.

In deaths that will be covered nationally, such as of celebrities, or those apt to be covered locally, such as persons living in small towns, consider phrasing for headlines such as: "Marilyn Monroe dead at 36," or "John Smith dead at 48." Consideration of how they died could be reported in the body of the article.

In the body of the story, it is preferable to describe the deceased as "having died by suicide," rather than as "a suicide," or having "committed suicide." The latter two expressions reduce the person to the mode of death, or connote criminal or sinful behavior.

Contrasting "suicide deaths" with "non-fatal attempts" is preferable to using terms such as "successful," "unsuccessful" or "failed."

Special Situations

Celebrity Deaths

Celebrity deaths by suicide are more likely than non-celebrity deaths to produce imitation.[24] Although suicides by celebrities will receive prominent coverage, it is important not to let the glamour of the individual obscure any mental health problems or use of drugs.

Homicide-Suicides

In covering murder-suicides be aware that the tragedy of the homicide can mask the suicidal aspect of the act. Feelings of depression and hopelessness present before the homicide and suicide are often the impetus for both.[25,26]

Suicide Pacts

Suicide pacts are mutual arrangements between two people who kill themselves at the same time, and are rare. They are not simply the act of loving individuals who do not wish to be separated. Research shows that most pacts involve an individual who is coercive and another who is extremely dependent.[27]

Stories to Consider Covering:

- Trends in suicide rates
- Recent treatment advances
- Individual stories of how treatment was life-saving
- Stories of people who overcame despair without attempting suicide
- Myths about suicide
- Warning signs of suicide
- Actions that individuals can take to prevent suicide by others

***For references and resources, and for examples of appropriate and problematic coverage of suicide by the media, visit the American Foundation for Suicide Prevention website,* www.afsp.org.**

NEWSDESK: TOP STORIES

JPMorgan Chase Understands Employee Needs

Staff Writer
Mental Health News

More than 24,000 employees worldwide (30% of all workers) last year tapped into the expertise and insights offered by two of JPMorgan Chase's work-life programs: the Employee Assistance Program (EAP) and LifeWorks.

Both programs provide support and guidance to JPMorgan Chase employees—but of a slightly different nature. EAP is a confidential counseling program staffed by professional counselors who can meet with employees or their family members in person to discuss any personal issue that's affecting their health or job, such as emotional, family, relationship, job, substance abuse or other concerns. An employee need not be in a crisis situation to seek out EAP counselors. Many times, EAP counselors can help sort out a problem, offer direction or refer employees to an outside resource.

LifeWorks' experts provide information—either by phone or online—about a wide range of work-life issues. The information is of a non-clinical nature on issues like finding quality child care, tips and assistance when moving to a different town or neighborhood, college financial aid and elder care issues.

Both EAP and LifeWorks are offered at no cost to employees.

JPMorgan Chase recognizes that everyone has personal problems from time to time. By addressing these concerns early on, before they reach critical proportions, employees can avoid having them affect health or functioning. The JPMorgan Chase Employee Assistance Program is there to assist employees and their immediate family members with concerns about stress, depression or anxiety, marital, relationship or family problems, alcohol or drug abuse, job-related conflicts, financial or legal difficulties.

Counselors are professionally trained, licensed or certified mental health professionals. The EAP counselor helps assess the situation to determine a direction to resolve the problem, which can include short-term counseling, stress management training and/or referral to outside resources. All services provided by the EAP are free and confidential. If referral to some other professional is made and fees are involved, the counselor will help determine whether your medical benefits will offset some of the costs. Use of the EAP is voluntary and strictly confidential as required by law and JPMorgan Chase policy.

In addition to the services provided by the EAP, LifeWorks is available to help balance work and personal life issues. The LifeWorks family resource program provides information and support to deal with concerns related to being a working parent, the well-being of older relatives and balancing work/life responsibilities. LifeWorks delivers practical solutions, information, advice and support. It's effective and easy to use, and best of all, it's available anytime, wherever employees are.

LifeWorks offers free, confidential assistance 24 hours a day, seven days a week, as well as personalized confidential consultations, individualized referrals to resources in the community, free booklets, audiotapes/CDs and tip sheets.

"Talking About Mental Health"

Staff Writer
Mental Health News

There's a new voice for mental health on the airwaves and it's called "Talking About Mental Health." The show which premiered this past spring, is broadcast on New Rochelle, WVOX 1460 AM and is hosted by Michael Blumenfield, M.D., Professor of Psychiatry at New York Medical College's Behavioral Health Center campus in Valhalla.

"Talking About Mental Health" airs every Tuesday from 3-4 p.m. and then is rebroadcast each Wednesday evening from 7-8 p.m.

Dr. Blumenfield begins each program with comments on a mental health topic, which is then followed with an in-depth interview with a special guest. There are also open phone lines where listeners can join in on the conversation.

With the assistance of the show's producer, Ruth Shaker, M.S.W., a Social Worker also from the Department of Psychiatry at the Behavioral Health Center, Dr. Blumenfield has interviewed a series of guests from around the country and from the show's home in Westchester County.

Some of the guests have included Nada Stotland, M.D., nationally known expert on women's issues and the stigma of mental illness; local child psychiatrists Beth Belkin, M.D., and Donald Heacock, M.D. who each spoke on various aspects of violence in children and teenagers; Ken Pollack, Ph.D., psychologist and leading expert on sexuality; Abe Halpern, M.D., nationally known forensic psychiatrist; Tim Sullivan, M.D., from St. Vincent's Hospital Center in Harrison who spoke on the seriously mentally ill; Alvin Pam, Ph.D., author and expert on divorce; and just recently Ira Minot, C.S.W., founder and publisher of Mental Health News.

Dr. Michael Blumenfield and Ira Minot

Future guests on the show will be Fred Sheftell, M.D., expert on headaches, Mark Ligorski, M.D., who will speak on "superheroes" and Steven Friedman, Westchester County's Commissioner of Mental Health.

According to Dr. Blumenfield, "we are reaching out to the community with a message that it's ok to talk openly about mental illness and we try to break down stigma thru this new dialogue."

NYS Health Department's New Regulations Guarantee Penalties for Deficient Adult Homes

Staff Writer
Mental Health News

As a follow up to our editorial "Leben Home Scandal...a wake-up call for all of us" (Mental Health News, Summer 2001), the NYS Department of Health issued the following revision to its policies on monitoring adult home conditions.

On June 5, the NYS Department of Health, the state's lead agency for the licensing and oversight of adult homes, issued new emergency regulations that shores up its authority to levy fines for adult homes found to have "dangerous or unhealthy conditions."

Previously, DOH was required to give facility operators 30 days to correct cited violations, including systemic deficiencies that would avoid their having to pay costly fines.

The new regulations would require that adult home operators found to operate seriously deficient homes would have to pay those fines regardless, at $1,000 a day, until they fix up their homes.

"This new regulation will ensure that facilities are maintained in a safer and more sanitary condition and that residents are better protected, by requiring operators to establish a system for maintaining each area of operation (nutrition, medication management, fire/safety equipment, etc) in such a way as to assure that residents' health, safety and welfare are not endangered or caused harm," said DOH officials in a recent letter to adult home operators.

DOH'S adoption of this emergency regulation makes it effective immediately, for the next 90 days, while public comment is sought to make it permanent.

While this action bolsters enforcement around physical plant safety, advocates continue to seek state action in improving the physical and mental health care adult home residents receive...and badly needed increases in their clothing and monthly spending allowances.

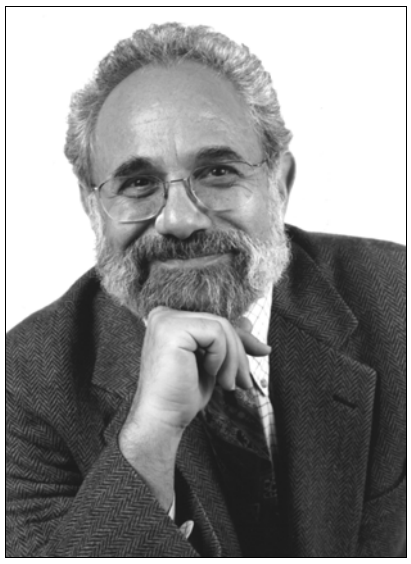
Source: NYAPRS

Mental Health News wishes to give recognition & special thanks to Jane E. McCarty for her outstanding and dedicated assistance in editing this issue.

NEWSDESK: TOP STORIES

New York State's Five-Year Plan for Mental Health: The Right Directions But How Extensive Is The Commitment?

By Michael B. Friedman, CSW
Public Policy Analyst



Michael B. Friedman, C.S.W.

In the Spring of 2001, The Office of Mental Health released a Five-Year Plan creating an important opportunity to understand and to comment on the mental health policy of New York State. Two hearings were held. Below is the statement I presented on behalf of the Mental Health Associations of New York City and Westchester County at the hearing in New York City on June 26, 2001.

The most fundamental commitment in The Office of Mental Health's Five-Year Plan is to the continuation of a community mental health policy in New York State. This is a commitment which the Mental Health Association movement shares. Indeed it is fundamental to our organizational mission that no one should be treated in an institutional setting if it is possible to provide them the care and treatment they need in the community. Thus we strongly support the State's intention to continue to reduce the utilization of State psychiatric centers, including closure of facilities when possible, and to expand and improve the system of community-based mental health services.

Expand and improve! It is important to do both. And the broad themes struck in the plan regarding how to improve the mental health system are quite encouraging, particularly the emphasis on hope and recovery, on recipient and family involvement, on improving the quality of treatment, on accountability, and on enhancing coordination in the mental health system.

We are also encouraged that the plan acknowledges so clearly the need to expand the mental health system to serve people already in the community who are not currently adequately served.

As the plan notes, children and adolescents with emotional disturbances in New York State are underserved and often inappropriately served. We agree that there is need for:

- Expansion of community-based services including both treatment and community support services,
- Reshaping of services at the community level so that they are more intensive, flexible and responsive to crisis,
- Focusing more intensively on early identification and intervention,
- Improved coordination with other service systems, and
- Intensive focus on the need to improve quality of treatment and care through training and research.

As the plan also notes, a great deal more effort is needed to reach and engage adults with serious and recurrent mental illnesses who tend to reject traditional mental health services. Of particular concern are people with co-occurring psychiatric and addictive disorders and people caught up in the criminal justice system. To reach and engage these people we need:

- More extensive outreach services such as assertive community treatment and intensive case management,
- More supported housing,
- More peer advocacy services,
- Intensive focus on relapse prevention, and
- More treatment programs that integrate mental health and substance abuse services.

We also need a comprehensive initiative regarding people with mental illnesses who end up in jails and prisons. This should include:

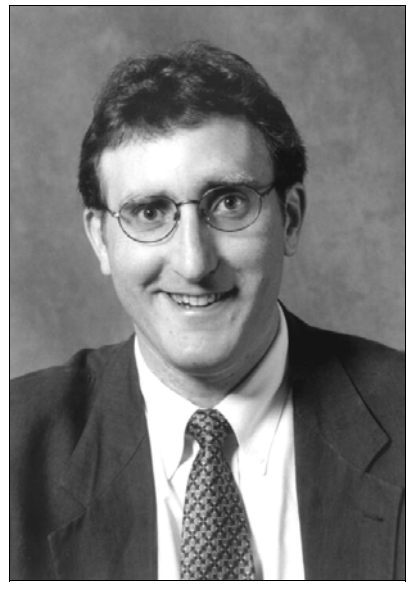
- Improved crisis services,
- Jail diversion services,
- Improved treatment services and suicide prevention in jails and prisons,
- Better treatment planning at the time

see *Right Directions* on page 28

New Freedoms, Old Barriers, and New Threats

By Andrew J. Imparato
President and CEO
American Association of
People with Disabilities

As we celebrate the 11th anniversary of the Americans with Disabilities Act (ADA) this July 26, we have an opportunity to celebrate the progress that has occurred since 1990 and to recommit ourselves to addressing the many ongoing barriers to full participation that lie before us as a cross-disability community. In that spirit, I have compiled a list of eleven "new freedoms" or signs of progress. By emphasizing these "new freedoms," I don't intend to downplay the importance of the "old barriers" (e.g., the institutional bias in the Medicaid program, work disincentives in disability benefits programs, or persistent attitudinal barriers perpetuated by mainstream media) and "new threats" (e.g., states' rights, genetic discrimination, and the ADA Notification Act). However, in the spirit of a celebration, I have decided to focus my column on the positive as we mark 11 years of ADA.



Andrew J. Imparato

New Freedoms--Signs of Progress from 2000-2001

1. Vote 2000 and Disability Vote Project. Thanks to the leadership of Jim Dickson, Adina Topfer, and the numerous individuals and organizations that participated in get out the vote efforts around the 2000 national elections, we are beginning to make our disability voice heard in the polling place. According to the National Organization on Disability (NOD), approximately 14 million people with disabilities voted in November of 2000, or about 40 percent of eligible voters with disabilities. That represents a 2.7 million-vote increase over the 1996 elections. Jim and Adina will continue to build on this significant progress from their new positions at the American Association of People with Disabilities (AAPD), working in coalition as always with folks and organizations around the country.

2. Cingular Wireless's Dan Keplinger Super Bowl Ad. In January, 2001, Cingular Wireless ran an ad during the Super Bowl that featured disabled artist Dan Keplinger talking about the importance of self expression. At the end of the ad, Dan voiced and the screen captioned the words "I am so lucky." This positive message coming from an artist with a significant disability was a marked improvement over the message of the prior year's Nuveen Investments Super Bowl ad featuring Christopher Reeve "walking" with the assistance of computer-generated "cured" legs. The message of Cingular's ad was that it is okay to be disabled. Nuveen's message was stuck in the medical model, celebrating the eventual "cure" for spinal cord injuries. Go Cingular! Go Dan!

3. 2000 Paul G. Hearne/AAPD Leadership Awardees. In December, 2000, AAPD recognized eleven emerging leaders with disabilities from around the country. To learn about the group, and the 1999 awardees, visit www.aapd-dc.org and/or www.nationalleaders.com/hearne for more information. The 2000 awardees, like their predecessors from 1999, are an impressive testament to the power of the cross-disability leaders who are beginning to make their voices heard around the U.S. Kudos to Olegario Cantos VII, Matthew Cavedon, Robert E. Coward, Jr., Tamar Michai Freeman, Kyle Glozier, James Sato Harrold, Tim Holmes, James R. Meadours, Sharon Lynn Nguyen, Lauren Teruel, and Sabrina-Marie Wilson! The deadline for the

see *New Freedoms* on page 28

Hope For Recovery - Understanding PTSD

By the PTSD Alliance

One man walks away from a car accident uninjured, but the driver of the other car is killed.

A woman is attacked in her home in the middle of the day.

A family escapes from their burning house.

A woman's close friend is killed in a freak boating accident.

A man is diagnosed with a brain tumor.

A woman endures 15 years of abuse in her marriage.

All are terrible life experiences, but can they lead to the development of posttraumatic stress disorder, or PTSD? The answer is a profound YES.

When most people hear the term PTSD, they think about combat veterans, survivors of natural disasters, or victims of violent crimes. But PTSD can affect anyone who has experienced, witnessed or learned about any life-threatening traumatic event or ordeal, or psychologically distressing situation – an experience that causes the person to feel intense fear, horror or a sense of helplessness.

An estimated 70 percent of American adults have been exposed to extreme trauma at least once in their lives and up to 20 percent of these people may go on to develop PTSD. More common then asthma or diabetes, PTSD is the fifth most commonly diagnosed psychiatric disorder. Unfortunately, despite the fact that PTSD affects one out of 13 Americans, it is not widely understood among the general public and often goes unrecognized and untreated by professionals who deal with those at risk for developing PTSD.

In March 2000, the PTSD Alliance was established to address this unmet need in increasing awareness of the prevalence, diagnosis and treatment of PTSD. The four founding member organizations, representing a spectrum of health issues related to PTSD including traumatic stress, anxiety disorders and women's healthcare, are:

- The American College of Obstetricians and Gynecologists (ACOG)
- The Anxiety Disorders Association of America (ADAA)
- The International Society for Traumatic Stress Studies (ISTSS)
- The Sidran Traumatic Stress Foundation

The PTSD Alliance is supported by an unrestricted educational grant from Pfizer Inc.

"The PTSD Alliance is the first national coalition dedicated to educating the public about this prevalent and complex disorder," said Jerilyn Ross, MA, LICSW, President and CEO of the Anxiety Disorders Association of America. "Our goal is to help people at risk, and their families and friends, to better understand PTSD and how it relates to extreme trauma, and to provide direction on where to go for more information on treatment and support."

The PTSD Alliance also provides information to a broad cross section of healthcare and other frontline professionals who come in contact with at-risk individuals and PTSD sufferers every day, and play a critical role in the recognition and treatment of PTSD. Frontline professionals include: psychiatrists, family practitioners and obstetricians-gynecologists; nursing professionals, physician assistants and other allied health professionals; psychologists, social workers and other mental health professionals; counselors in domestic violence shelters, substance abuse programs or rape crisis centers; and emergency support or disaster relief personnel.

To arm consumers and professionals with information about PTSD, the PTSD Alliance launched an education campaign and established a National Resource Center available through a toll free number, 877-507-PTSD. The Resource Center serves as a clearinghouse for educational resources and referral information from the member organizations. Also available from the Resource Center are a patient education booklet and video, as well as a guide for professionals, developed by the PTSD Alliance. These educational materials also can be obtained through the web site, www.PTSDAlliance.org.

To further reach professionals, the PTSD Alliance places public service ads in healthcare trade publications highlighting the need to assess trauma history. The PTSD Alliance also reaches professionals through exhibits and speaker presentations at various medical and healthcare educational conferences throughout the year.

PTSD DIAGNOSIS AND TREATMENT

PTSD often affects victims of interpersonal violence such as rape, or physical or sexual assault, including childhood abuse or domestic violence. Women are twice as likely as men to have PTSD. Others at risk include survivors of serious accidents, natural disasters, or other major catastrophic events, such as plane crashes or terrorist attacks; and combat and civilian victims of war.

People with PTSD experience three "clusters" of symptoms that last for more than one month. These symptoms may affect many aspects of a person's life, in particular, affecting day-to-day functioning, quality of life and relationships.

The three clusters are characterized by the following:

- **Re-experiencing** the trauma, such as dreaming about the event, or "re-living" the event when faced with reminders;
- **Avoiding reminders** of the trauma, withdrawing from family or friends, feeling numb or no longer enjoying daily life;
- **Being on-guard** or hyperaroused, having difficulty sleeping, becoming easily agitated or irritable, or having a hard time concentrating.

PTSD symptoms usually develop within the first three months after the trauma, but may not appear until months or years have passed. These symptoms may continue for years following the trauma, or in some cases, symptoms may subside and return later in life.

"Within our society, people commonly feel that no matter what has happened in the past—no matter how terrible or distressing—you should be able to get past it at some point and get on with your life. But this is a myth," said Esther Giller, MA, executive director of the Sidran Traumatic Stress Foundation.

"PTSD can affect every aspect of a person's life—at home, at work, with their relationships with family and friends. It can affect your ability to cope and can cause you to lose a sense of connection and control over your life," said Ms. Giller. "For months, even years after experiencing trauma, PTSD sufferers may feel helpless, empty emotionally and isolated from loved ones. They may have physical symptoms that can't be explained. Often they don't seek help because they don't make the connection that their symptoms are a reaction to past trauma."

Once diagnosed by a qualified healthcare professional, PTSD is treatable with psychotherapy, medication or a combination of both. Research suggests treatment may help patients recover even if initiated in the years following the trauma and the onset of symptoms. Family and friends play an important role in recognizing PTSD symptoms. They can help to improve a PTSD sufferer's chance of recovery by encouraging them to seek treatment and by providing emotional support.

"The goal of the PTSD Alliance is to help those in need to take that first step in regaining their lives," said Edna Foa, Ph.D. with the International Society of Traumatic Stress Studies, and Professor, Department of Psychiatry and Director, Center for the Treatment and Study of Anxiety at the University of Pennsylvania School of Medicine. "We want people to understand that having PTSD is not an inevitable consequence of their traumatic experience. There is hope for recovery through proper diagnosis, treatment and support."

Sidran Traumatic Stress Foundation...Leaders In PTSD Education, Advocacy and Resources

By Esther Giller
President and Director
The Sidran Foundation

Many adults and children who have experienced or witnessed violent or traumatic events suffer severe and disabling symptoms of distress. The developmental, emotional and psychological injuries caused by violence and trauma are frequently underestimated and largely misunderstood.

Sidran Traumatic Stress Foundation is a nonprofit charitable organization devoted to education, advocacy, and resources to benefit people who are suffering from injuries of traumatic stress. Whether caused by family violence, crime, disasters, war, or any other overwhelming experience, Sidran believes that the disabling effects of trauma can be overcome with understanding, support, and appropriate treatment.

Sidran grew out of my own family's need to learn about and share information about the effects of trauma. In 1987, as a close family member (trauma survivor) lay critically ill as a result of mismanagement of psychiatric medication, my parents and I decided to "transform the pain" into a tool to share understanding. With the clinical and moral support of Dr. Frank Putnam, then chief of Developmental Traumatology at NIMH, and Linda Blick, founder of the Chesapeake Institute (an award-winning D.C.-area program for the investigation and treatment of child sexual abuse), and the financial support of Mrs. Kate Sidran, of Dallas, the seeds of Sidran Foundation were sown.

The foundation was named in honor of the Sidran (pronounced SID-run) family, whose generous contribution provided this organization's original endowment. We gratefully acknowledge that the Sidran family continues to provide approximately 10% of the organization's operating funds.

Now, almost 15 years later, Sidran is one of the leading organizations providing supportive education and training, publications and informational resources on a variety of issues related to traumatic stress.

Sidran's philosophy is built around four concepts:

1) Sidran is devoted to the idea that in order to identify and respond effectively to the needs of trauma survivors, we need to look through the "lens of trauma" rather than using the "medical model" approach typical of mainstream psychiatry. This doesn't mean that psychiatry has little to offer trauma survivors, because many survivors benefit greatly from medication for symptom management, but that first and basic question needs to be "what happened to you?" rather than "what's wrong with you?

2) Because the traumatic experiences that are the most debilitating are those that involve the violation of interpersonal boundaries and betrayal of social expectations (rape, abuse, assault, combat, torture, etc.), healing must take place in an interpersonal, relational context. Survivors, family members, therapists, and other providers of services have the mutual goal of building healthy relationships to promote recovery.

3) Symptoms are meaningful adaptations to traumatic experiences. They are "best effort" attempts to cope with overwhelming thoughts and feelings. If the meanings are understood and the coping objectives are met in other ways, the "symptoms" can be successfully managed.

4) Vicarious trauma affects the people who live and work with survivors in ways that may impact their own abilities to be helpful. Attention paid to the well-being of support people will contribute greatly toward the recovery of the survivor.

To support people with traumatic stress conditions, and to educate health providers, significant others, and the public, Sidran has developed the following programs and projects:

THE SIDRAN PRESS publishes books and educational materials on traumatic stress and dissociative conditions for consumers, supportive others and treatment providers. We have developed a series of self-help workbooks for consumer survivors, training materials for workers in treatment agencies, and writings by survivors about their experiences in the treatment "system." All of our publications are informed by consumer and clinician input. Here are a few examples:

· *Risking Connection: a Training Curriculum for Working with Survivors of Childhood Trauma* is a groundbreaking program for use in teaching mental health professionals and paraprofessionals who work in mental health agencies. This unique program was generated by consumer demand, and developed in collaboration with authors from the Traumatic Stress Institute, and the departments of mental health in Maine in New York. *Risking Connection* is the only training program designed to facilitate the paradigm shift from "medical model" to "trauma model" in services provider agencies.

· *Growing Beyond Survival: A Self-help Tool Kit for Managing Traumatic Stress*, by Sidran Training Director Elizabeth Vermilyea, is a symptom management workbook for trauma survivors that can be used in individual therapy, in groups, and on your own. The development of this book was strongly supported by consumers in New York State.

· **Forthcoming, Fall 2001**---*Getting Real (With Yourself and Others): Relational Peer Support for Men and Women with Histories of Trauma*, a new framework for building mutual support programs for trauma survivors.

· Other recent titles include *Secondary Traumatic Stress*, *Unspeakable Truths and Happy Endings*, and workbooks *Managing Traumatic Stress through Art and The Way of the Journal*.

THE SIDRAN BOOKSHELF ON TRAUMA AND DISSOCIATION is an annotated mail order catalog of the best in clinical, educational, and survivor-supportive literature on posttraumatic stress and dissociative conditions and related subjects. The catalog is also available online at www.sidran.org/bookshelf.html.

THE SIDRAN TRAUMABASE is a comprehensive computerized information database of resources, including nationwide (and some international) listings of therapists, organizations, conferences, trainings, and facilities for specialized treatment. Contact us to contribute information about your organization, program or practice.

THE SIDRAN RESOURCE SERVICE, drawing from the TraumaBase and Sidran's extensive library, provides resources and referrals at no cost to callers from around the English-speaking world. Literature searches and reprints are available at a modest fee.

SIDRAN EDUCATION AND TRAINING SERVICE provides agency training on many trauma-related topics, including Issues Contributing to Re-Victimization, Shame in Treatment, Borderline Personality Disorder, and others. Intensive training to support Sidran's *Risking Connection* program and *Growing Beyond Survival* is now available. We will be glad to customize presentations for the specific needs of your agency. Sidran has also developed educational workshops on the psychological effects of severe trauma for a variety of audiences: adult survivors, partners and supporters, primary care physicians, caregivers of abused children (including foster care), and non-clinical professionals (such as teachers, social services personnel, clergy, corrections officers, etc.).

SIDRAN OUTREACH AND ADVOCACY SERVICE focuses on the educational and linkage needs of survivors. This survivor run program provides consultation to survivors starting peer support groups, building community networks, and developing local trauma-informed programming. We attend consumer/survivor conferences, share information and resources, and teach self-advocacy by modeling it. The *Getting Real* peer support program was developed by this service, with the support of the Maryland Department of Mental Health, Office of Special Populations.

THE PTSD ALLIANCE, a collaborative, on-going public and media education effort between Sidran Foundation and three other nonprofit organizations, was established in 2000 to increase general understanding about Posttraumatic Stress Disorder. Alliance partners include the American College of Obstetricians and Gynecologists, The International Society for Traumatic Stress Studies, and the Anxiety Disorders Association of America. The PTSD Alliance was made possible by an unrestricted educational grant from Pfizer.

THE TAMAR PROGRAM, originally a federally funded "Women and Violence" study site in Maryland, this program is now a part of the Maryland Department of Mental Health. It provides integrated, trauma sensitive mental health services for incarcerated men and women who have histories of abuse trauma. As the education and training provider for this program, the Sidran Foundation has developed trauma training for correctional staff and community agencies.

New initiatives for the coming year include the development of *Risking Connection* program enhancements for specific audiences, including clergy, child treatment agencies, and domestic violence settings.

Please contact us for more information about any of these programs and projects at Sidran Traumatic Stress Foundation, 200 E. Joppa Road, Suite 207, Baltimore, MD 21286, or call us directly at 410-825-8888. Our e-mail address is sidran@sidran.org, and please be sure to visit our webite at www.sidran.org.

Sidran
TRAUMATIC STRESS FOUNDATION

What Is Psychological Trauma?

By Esther Giller
President and Director
The Sidran Foundation

We all use the word "trauma" in every day language to mean a highly stressful event. But the key to understanding traumatic events is that it refers to extreme stress that overwhelms a person's ability to cope. There are no clear divisions between stress, (which leads to) trauma, (which leads to) adaptation. Although I am writing about psychological trauma, it is also important to keep in mind that stress reactions are clearly physiological as well.

Different experts in the field define psychological trauma in different ways. What I want to emphasize is that it is an individual's *subjective experience* that determines whether an event is or is not traumatic.

Psychological trauma is the unique individual experience of an event or enduring conditions, in which: the individual's ability to integrate his/her emotional experience is overwhelmed, or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity. (Pearlman & Saakvitne, 1995, p. 60).

Thus, a traumatic event or situation creates psychological trauma when it overwhelms the individual's perceived ability to cope, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual feels emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss.

This definition of trauma is fairly broad. It includes responses to powerful one-time incidents like accidents, natural disasters, crimes, surgeries, deaths, and other violent events. It also includes responses to chronic or repetitive experiences such as child abuse, neglect, combat, urban violence, concentration camps, battering relationships, and enduring deprivation.

This definition intentionally does not allow *us* to determine whether a particular event is traumatic; that is up to each survivor. This definition provides a guideline for our understanding of a survivor's experience of the events and conditions of his/her life.

Jon Allen, a psychologist at the Menninger Clinic in Topeka, Kansas and author of *Coping with Trauma: A Guide to Self-Understanding* (1995) reminds us that there are two components to a traumatic experience: the objective and the subjective.

"It is the subjective experience of the objective events that constitutes the trauma...The more you believe you are endangered, the more traumatized you will be... Psychologically, the bottom line of trauma is overwhelming emotion and a feeling of utter helplessness. There may or may not be bodily injury, but psychological trauma is coupled with physiological upheaval that plays a leading role in the long-range effects" (p.14).

In other words, trauma is defined by the *experience of the survivor*. Two people could undergo the same noxious event and one person might be traumatized while the other person remained relatively unscathed. It is not possible to make blanket generalizations such that "X is traumatic for all who go through it" or "event Y was not traumatic because no one was physically injured." In addition, the specific aspects of an event that are traumatic will be different from one individual to the next. You cannot assume that the details or meaning of an event, such as a violent assault or rape, that are most distressing for one person will be same for another person.

Trauma comes in many forms, and there are vast differences among people who experience trauma. But the similarities and patterns of response cut across the variety of stressors and victims, so it is very useful to think broadly about trauma.

Single Blow vs.
Repeated Trauma

Lenore Terr, in her studies of traumatized children, has distinguished made the distinction between single blow and repeated traumas. Single shocking events can certainly produce trauma reactions in some people:

· *Natural disasters* such as earthquakes, hurricanes, floods, volcanoes, etc.

· Closely related are *technological disasters* such as auto and plane crashes, chemical spills, nuclear failures, etc. Technological disasters are more socially divisive because there is always energy given towards finding fault and blaming.

· *Criminal violence* often involves single blow traumas such as robbery, rape and homicide, which not only have a great impact on the victims, but also on witnesses, loved ones of victims, etc. (Interestingly, there is often overlap between single blow and repeated trauma, because a substantial majority of victimized women have experienced more than one crime.) Unfortunately, traumatic effects are often cumulative.

As traumatic as single-blow traumas are, the traumatic experiences that result in the most serious mental health problems are prolonged and repeated, sometimes extending over years of a person's life.

Natural vs. Human Made

Prolonged stressors, deliberately inflicted by people, are far harder to bear than accidents or natural disasters. Most people who seek mental health treatment for trauma have been victims of violently inflicted wounds dealt by a person. If this was done deliberately, in the context of an ongoing relationship, the problems are increased. The worst situation is when the injury is caused deliberately in a relationship with a person on whom the victim is dependent---most specifically a parent-child relationship.

Varieties of Man-Made Violence

· *War/political violence* - Massive in scale, severe, repeated, prolonged and unpredictable. Also multiple: witnessing, life threatening, but also doing violence to others. Embracing the identity of a killer.

· *Human rights abuses* - kidnapping, torture, etc.

· *Criminal violence* - discussed above.

· *Rape* - The largest group of people with posttraumatic stress disorder in this country. A national survey of 4000 women found that 1 in 8 reported being the victim of a forcible rape. Nearly half had been raped more than once. Nearly 1/3 was younger than 11 and over 60% were under 18. Diana Russell's research showed that women with a history of incest were at significantly higher risk for rape in later life (68% incest history, 38% no incest).

· *Domestic Violence* - recent studies show that between 21% and 34% of women will be assaulted by an intimate male partner. Deborah Rose's study found that 20-30% of adults in the US, approved of hitting a spouse.

· *Child Abuse* - the scope of childhood trauma is staggering. Everyday children are beaten, burned, slapped, whipped, thrown, shaken, kicked and raped. According to Dr. Bruce Perry, a conservative estimate of children at risk for PTSD exceeds 15 million.

· *Sexual abuse* - According to Dr. Frank Putnam of NIMH, at least 40% of all psychiatric inpatients have histories of sexual abuse in childhood. Sexual abuse doesn't occur in a vacuum: is most often accompanied by other forms of stress and trauma-generally within a family.

We must be careful about generalizations about child sexual abuse: research shows that about 1/3 of sexually abused children have no symptoms, and a large proportion that do become symptomatic, are able to recover. Fewer than 1/5 of adults who were abused in childhood show serious psychological disturbance.

More disturbance is associated with more severe abuse: longer duration, forced penetration, helplessness, fear of injury or death, perpetration by a close relative or caregiver, coupled with lack of support or negative consequences from disclosure.

· Physical abuse often results in violence toward others, abuse of one's own children, substance abuse, self-injurious behavior, suicide attempts, and a variety of emotional problems.

· *Emotional/verbal abuse*

· *Witnessing*. Seeing anyone beaten is stressful; the greater your attachment to the victim, the greater the stress. Especially painful is watching violence directed towards a caregiver, leaving the child to fear losing the primary source of security in the family.

· *Sadistic abuse* - we generally think about interpersonal violence as an eruption of passions, but the severest forms are those inflicted deliberately. Calculated cruelty can be far more terrifying than impulsive violence. Coercive control is used in settings like concentration camps, prostitution and pornography rings, and in some families.

One of the best-documented research findings in the field of trauma is the DOSE-RESPONSE relationship --the higher the dose of trauma, the more potentially damaging the effects; the greater the stressor, the more likely the development of PTSD.

The most personally and clinically challenging clients are those who have experienced repeated *intentional* violence, abuse, and neglect from childhood onward. These clients have experienced tremendous loss, the absence of control, violations of safety, and betrayal of trust. The resulting emotions are overwhelming: grief, terror, horror, rage, and anguish.

Their whole experience of identity and of the world is based upon expectations of harm and abuse. When betrayal and damage is done by a loved one who says that what he or she is doing is good and is for the child's good, the seeds of lifelong mistrust and fear are planted. Thus, the survivor of repetitive childhood abuse and neglect *expects* to be harmed in any helping relationship and may interact with us as though we have already harmed him or her.

Summary

Psychological effects are likely to be most severe if the trauma is: human caused, repeated, unpredictable, multifaceted, sadistic, undergone in childhood, and perpetrated by a caregiver.

Who Are Trauma Survivors?

Because violence is everywhere in our culture and because the effects of violence and neglect are often dramatic and pervasive.*most clients/patients/recipients of services in the mental health system are trauma survivors.*

Because coping responses to abuse and neglect are varied and complex, *trauma survivors may carry any psychiatric diagnosis and frequently trauma survivors carry many diagnoses.*

And, because interpersonal trauma does not discriminate, *survivors are both genders, all ages, all races, all classes, all sizes, all sexual orientations, all religions, and all nationalities.* Although the larger number of our clients are female, many men and boys are survivors of childhood abuse and trauma. Under-recognition of male survivors, combined with cultural gender bias has made it especially difficult for these men to get help.

What are the Lasting Effects of Trauma?

There is no one diagnosis that contains all abuse survivor clients; rather individuals carrying any diagnosis can be survivors. Often survivors carry *many* diagnoses.

see *Trauma* on page 11

What Is Psychological Trauma?

***Trauma* from page 10**

Abuse survivors may meet criteria for diagnoses of: substance dependence and abuse, personality disorders (especially borderline personality disorder), depression, anxiety (including posttraumatic stress disorder), dissociative disorders, and eating disorders, to name a few.

PTSD is the only diagnostic category in the DSM that is based on etiology. In order for a person to be diagnosed with PTSD, there had to be a traumatic event. Because most diagnoses are descriptive and not explanatory, they focus on symptoms or behaviors without a context: they do not explain how or why a person may have developed those behaviors (e. g., to cope with traumatic stress).

For purposes of identifying trauma and it adaptive symptoms, it is much more useful to ask "What HAPPENED to this person" rather than "what is WRONG with this person."

Symptoms as Adaptations

The traumatic event is over, but the person's reaction to it is not. The intrusion of the past into the present is one of the main problems confronting the trauma survivor. Often referred to as *re-experiencing*, this is the key to many of the psychological symptoms and psychiatric disorders that result from traumatic experiences. This intrusion may present as distressing intrusive memories, flashbacks, nightmares, or overwhelming emotional states.

The Use of Maladaptive Coping Strategies

Survivors of repetitive early trauma are likely to instinctively continue to use the same self-protective coping strategies that they employed to shield themselves from psychic harm at the time of the traumatic experience. *Hypervigilance, dissociation, avoidance and numbing* are examples of coping strategies that may have been effective at some time, but later interfere with the person's ability to live the life s/he wants.

It is useful to think of all trauma "symptoms" as adaptations. Symptoms represent the client's attempt to cope *the best way they can* with overwhelming feelings. When we see "symptoms" in a trauma survivor, it is always significant to ask ourselves: what purpose does this behavior serve? Every symptom helped a survivor cope at some point in the past and is still in the present—in some way. We humans are incredibly adaptive creatures. Often, if we help the survivor explore how behaviors are an adaptation, we can help them learn to substitute a less problematic behavior.

Developmental Factors

Chronic early trauma -- starting when the individual's personality is forming—shapes a child's (and later adult's) perceptions and beliefs about everything. Severe trauma can have a major impact on the course of life. Childhood trauma can cause the disruption of basic developmental tasks. The developmental tasks being learned at the time the trauma happens can help determine what the impact will be. For example, survivors of childhood trauma can have mild to severe deficits in abilities such as: self-soothing, seeing the world as a safe place, trusting others, organized thinking for decision-making and avoiding exploitation

Disruption of these tasks in childhood can result in adaptive behavior, which may be interpreted in the mental health system as "symptoms." For example, disruptions in abilities for: self-soothing = agitation; seeing the world as a safe place = paranoia; trusting others = paranoia; organized thinking for decision-making = psychosis; avoiding exploitation = self-sabotage.

Physiologic Changes

The normal physiological responses to extreme stress lead to states of physiologic hyperarousal and anxiety. When our fight-or-flight instincts take over, the wash of cortisol and other hormones signal us to watch out! We humans are incredibly adaptive. When this happens repeatedly, our bodies learn to live in a constant state of "readiness for combat," with all the behaviors-scanning, distrust, aggression, sleeplessness, etc. that entails.

Cutting edge neurological research is beginning to show to what extent trauma effects us on a biological and hormonal basis as well as psychologically and behaviorally. Research suggests that in trauma, interruptions of childhood development and hypervigilance of our autonomic systems are compounded and reinforced by significant changes in the hard-wiring of the brain.

This may make it even more challenging (but not impossible) for survivors of childhood trauma to learn to do things differently. But it may also hold the promise of pharmaceutical interventions to address the biological/chemical effects of child abuse.

So, as scientists learn more about what trauma is, we are seeing see that it is truly a complex mixture of biological, psychological, and social phenomena.

This article originated as a workshop presentation at the Annual Conference of the Maryland Mental Hygiene Administration, "Passages to Prevention: Prevention across Life's Spectrum," May 1999.

References Provided On Request

PTSD - And How It Relates To Eating Disorders

By Judy Scheel, Ph.D.

Exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury or threat to one's physical integrity is included in the description of the diagnosis for posttraumatic stress disorder. The diagnostic classification continues. *For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury.* (DSM pg. 424) Physical and/or sexual abuse, incest and rape are all included in the events hailing the diagnosis of PTSD. The findings remain inconsistent, however, as to the link between the development of an eating disorder in response to childhood sexual and/or physical abuse

During the 1980's some studies indicated that incest or other sexual abuse typically preceded the onset of the later development of an eating disorder. (Waller, G. 1991) Statistics varied from more than one third of all incidences of anorexia and particularly bulimia nervosa had its origins in childhood abuse to its occurrence being as frequent as are the occurrences among the 'non eating disordered' psychiatric population. (Palmer in Brownell & Fairburn 1995) What seems to remain clear, however, is that one cannot assume that individuals who have eating disorders have had a history of prior sexual and or physical abuse. Contrarily, an individual who has been sexually or physically abused is at increased risk for the development of an eating disorder.

The diagnostic features associated with PTSD are of particular importance in the understanding of the etiology of eating disorders. The DSM IV states, "The traumatic event can be reexperienced in various ways. Commonly the person has recurrent and intrusive recollections of the event…In rare instances, the person experiences dissociative states that last from a few seconds to several hours…during which components of the event are relived and the person behaves as though experiencing the event at that moment. Intense psychological distress or physiological reactivity often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event…(DSM IV pg. 424).

One of the primary purposes of eating disorder symptomatology is to avoid and cope with painful, disquieting or uncomfortable feelings or affect. The eating disorder serves both to distance oneself from these feelings or states as well as to relieve them. From an abuse perspective, the eating disorder is a clever, albeit, destructive means to accomplish both distance and numbing as well as a means to relive the painful past events through a recreation of it through the eating disorder symptomatology. In effect, the individual with the eating disorder assumes roles of both the victim and abuser. S/he is typically at the mercy of the eating disorder symptomatology which can be quite sadistic (i.e. Laxative abuse, using a blunt instrument down the throat in order to vomit, starvation, binge eating until exhausted and physically in pain) as well as simultaneously assuming the role of the abuser who is in effect doing the harm, perpetrating the assault, to her own body. This paradigm fits with the relationship between the individual who is physically and/or sexually abused and the abuser, only this time, the sufferer is able to assume 'control' by taking on both roles. The individual therefore is able to maintain recurrent and intrusive abusive events through the use of the eating disorder while simultaneously enabling herself to dissociate, distract and sooth the pain through the obsession with food.

Triggering events of the traumatic event can initiate extreme present day psychological distress for the sufferer of PTSD. In this vein, feelings of shame, humiliation and guilt, whether perceived or actual events, can initiate a symptomatic response by the eating disorder sufferer. However, with eating disorders, these feelings are typically projected onto the body. For example, a woman presently suffering with bulimia who has a history of incest attends a party and perceives a man is looking at her. Assuming that the man is gazing appropriately and is seeking to make eye contact, the sufferer will convert the attention into fearing that the man is looking at her because she is fat and undesirable. The woman leaves the party feeling ashamed of her body and disgusted. She binges on carbohydrates and high fat food when she returns home and spends several hours vomiting. Upon analysis, the woman reports the shame, disgust and guilt she felt when as a child her father initiated his abuse of her by looking longingly at her. Her feelings of love for her father became distorted as she sought both his affection and was disgusted, horrified and terrified in the same breath. These feelings later became projected onto her body as an adult. The shame, disgust and guilt she feels now is experienced as believing she is fat, disgusting because of her eating disorder behavior, guilty over eating too much and shameful about her eating disorder which is a 'secret,' not unlike the secret of the incest.

For some eating disorder sufferers, memories of the abuse remains repressed. The eating disorder symptomatology further ensures the psychic coma; the eating disorder consumes an enormous amount of time, psychological energy and focus. Literally, there is no time to think about anything else.

What remains critical to keep in focus is that assumptions cannot be made about the development of an eating disorder; the causal factors are unique to the individual sufferer. Clearly, for all eating disorder sufferers there are deficits of one kind or another, which has lead to the development of the symptomatology. The impact of relationships and parenting in the development of self concept and self esteem, family dynamics, biological depression and anxiety disorders, cultural and societal pressures about weight and body image particularly for women, physical and/or sexual abuse, are all contributors in the development of eating disorders. All are significant. Which one(s) apply is unique to the individual. Post Traumatic Stress Disorder is indeed a condition which affects some individuals who have been victims of abuse, the manifestations of which may find expression via an eating disorder.

Judy Scheel, Ph.D., is Director of the Center for Eating Disorder & Recovery (CEDaR), in Mt. Kisco, NY, and Director of the Northern Westchester Hospital Center Eating Disorder Intensive Outpatient Program. She is also a member of the Eating Disorder Foundation, Inc. (a non-profit organization dedicated to prevention & education).

***Involuntary* from page 3**

result was that no one is using a tremendously valuable housing resource. The community is no safer than it was before—the AOT-designated person is still out of control—but Michael, who had done everything we expect of a consumer in terms of managing his own illness, has been harmed.

Fear has displaced a dispassionate and reasoned approach to the coordination of services and the triaging of resources. The issue of how resources and services can best be utilized has become secondary to fear-based calculations of risk and liability, and as more and more of the system is brought under a single point of entry, this attitude becomes more and more pervasive.

In their landmark report issued in January 2000 the National Council on Disability made ten core recommendations regarding the treatment of people with psychiatric disabilities. The very first said that: *Laws that allow the use of involuntary treatments such as forced drugging and inpatient and outpatient commitment should be viewed as inherently suspect, because they are incompatible with the principle of self-determination. Public policy needs to move in the direction of a totally voluntary community-based mental health system that safeguards human dignity and respects individual autonomy.*

There are ways to engage people who are marginalized and viewed as treatment-resistant that do not require expensive, coercive measures like AOT. For example, in Westchester there were many people who had been receiving little or no homeless outreach services. They sleep at the Drop-In Center, rather than residing at any of the regular county shelters. Many of these individuals are averse to relinquishing their monthly checks to the shelters for rent payment. This is commonly related to active substance abuse and often a distrust of the system. The Drop-In Center has no requirements to maintain a bed i. e. treatment, abstinence from substance abuse etc. Regular face-to-face contact is only possible at night. Drop-In Center clients are very difficult to engage and assist.

This year, with funding from the Department of Community Mental Health, CHOICE began a program specifically targeted to the Drop In Center. Homeless outreach workers in our Community Placement Team – peer professionals who were once homeless themselves -- make nightly visits to the Drop-In and are available in the capacity of advocates, mediators, and role models.

Since we began targeting the Drop-In Center in February 2001 twenty people have transitioned into the shelter system. Ten have continued to experience problems and move back and forth between the shelter and the Drop-In, but ten have successfully transitioned to housing in the community. That is the same number of people who were petitioned for AOT in the entire county.

Involuntary outpatient commitment was created by politicians to further political ends. It was not designed by mental health professionals as a means of service delivery. Mental health professionals can design and implement successful strategies to engage marginalized populations and should not be hindered by expensive political mandates like Kendra's Law. Rather than embracing AOT, the state Office of Mental Health should admit that it is a failure, and work in conjunction with advocates and mental health professionals to educate the people of New York State that coercion is not a viable avenue of treatment.

Joshua Koerner is the Executive Director of CHOICE

Weill Cornell Accident and Injury Recovery Program

Staff Writer
Mental Health News

Until recently, it was assumed that very few people, outside of combat veterans, would experience the kind of life-threatening traumatic events that put them at risk for Posttraumatic Stress Disorder (PTSD), and that even fewer would go on to develop PTSD. Moreover, it was believed that symptoms following a traumatic event were "normal" and were likely to subside on their own.

All this has changed in the past decade, according to Dr. JoAnn Difede, Assistant Professor of Psychology in Psychiatry and Director of the Weill Cornell Accident and Injury Recovery Program. Having discovered that seven out of ten people will experience a traumatic event during adult life—and that many will then suffer from Acute Stress Disorder (ASD) or PTSD—researchers have developed new, effective psychological and psychopharmacologic treatments. "These treatments give new hope to people suffering from the debilitating symptoms of these disorders," says Dr. Difede.

The Accident and Injury Recovery Program, located at NewYork-Presbyterian Hospital in Manhattan and the Westchester Division, helps individuals and families affected by accidents (burns, car or plane crashes); natural disasters (earthquakes, floods); illness or loss, as well as those who witness injury or death to others. Initial evaluations look for ASD, which occurs immediately after the event. If treated early, the patient is less likely to develop the more chronic PTSD.

The range of symptoms may include flashbacks, sleep difficulties, avoidance of reminders of the event, withdrawal from friends and family, and feelings of vulnerability or fear that bad things might happen to oneself or loved ones. Research shows that traumatic events can change the fundamental assumptions we make about ourselves and our surroundings. Survivors of disasters such as the World Trade Center bombing in 1993, for example, reported heightened feelings of vulnerability and helplessness. "You hear about bad things happening, but you never think it's going to be you," said one survivor.

Currently, Dr. Difede is conducting NIMH-funded research to develop and test psychological interventions, such as exposure therapy, for the treatment of ASD and PTSD following accidents, injury or life-threatening medical illness (such as heart attack or cancer).

Treatment in the Accident and Injury recovery Program is based on each patient's situation and may include short-term, individual therapy. Group therapy, and medication in some cases, may also be indicated. For family and friends of trauma victims, grief counseling and support groups are offered.

For further information on the accident and Injury Recovery Program, call (914) 997-8658 in White Plains, or (212) 746-3079 in Manhattan.

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    (Phobia, Depression and Anxiety Disorder Clinics, Clozapine Clinic, ECT Therapy)

- Child and Adolescent Services
  - *Inpatient, Day Hospital and Outpatient programs*
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Other services include community residence programs; the Sexuality Center; psychiatric home care; Drop-In Center; vocational and psychiatric rehabilitation; crisis intervention program; supportive living program, and strong linkages to self-help and advocacy groups.

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ECT: A Front-Line Treatment

By Samuel H. Bailine, M.D.
Physician In Charge of ECT
Hillside Hospital

Electro-convulsive therapy, (ECT) is a very safe effective treatment for a number of psychiatric disorders that has been in use for over 60 years.

Throughout this time many significant modifications have been made in the practice of ECT. These have been mostly to reduce the side effects and to make the treatment safer for the patient.

A lot of the critics of ECT focus on the period we call the "dark ages" of ECT. These are the years when ECT was given without anesthesia, which was perceived as the physician doing something that caused pain to the patient. The common notion we have is that anesthesia is given to prevent pain…so if you administer a procedure without anesthesia most people see this as analogous to amputating a leg without anesthesia. Many ECT practitioners are actually perpetuating this feeling in the public by now saying, "oh…now we give anesthesia." In doing so they are accepting the notion that without it they were causing pain.

In reality, ECT is a painless procedure, with or without anesthesia. The reason we give anesthesia is not to eliminate the pain associated with ECT…but to be able to give the person a neuromuscular blocking agent. Without the use of these agents, people (during the tonic phase of the electo-cunvulsive treatment) have in the past sustained orthopedic injuries caused from the strong muscular contractions produced during the ECT procedure. Without anesthesia, the patient would be exposed to the terrifying experience of losing all control of their muscles, including the respiratory muscles, while they were fully awake.

ECT even as depicted in One Flew Over The Cuckoo's Nest would not have caused the Jack Nicholson character the pain that he appears to be suffering. The notion that he is in pain is held because when convulsing the look on a person's face is that of pain. But the reality is that they are totally unconscious and do not feeling anything.

The way that ECT came about in the first place, was the observation (during the early part of the century), that people with epilepsy, who had the convulsive seizures inherent in epilepsy, exhibited less mental illness and less acute psychosis than the general population. That clue led to the belief that the epilepsy might be somehow beneficial to staving off mental illnesses. That led to the attempt to induce artificial epilepsy in people by giving them some agent to cause them to convulse. First chemicals were used, but they posed problems because they stayed in the body and could cause convulsions hours later. This could be very dangerous for the patients, who could fall and hurt themselves. Electrical stimulation allowed for a more controlled seizure which could be closely monitored by the physician.

Dr. Bailine in the ECT Lab at Hillside

A new and more modern look at ECT needs to take into account the notion of not only considering ECT as a last resort when years of medication trials have been unable to help the patient.

ECT is the treatment of choice to be given first in a number of situations such as in a patient who is acutely depressed, suicidal and psychotic. These patients are in immediate danger of taking their own life and need more immediate relief from their acute symptoms. The time delay in using medications could cause unnecessary suffering and poses a greater danger to the patient.

Even though the results are not instantaneous, ECT has proven to be over 90% effective in treating psychotic depressions and you expect that in within a week or two the patient is going to be better. With medications you are looking at five to six weeks before you are likely to get a satisfactory response. During that time, the severely depressed or psychotic patients is very hard to manage and are in danger of hurting themselves or others.

Another instance where ECT is the treatment of choice is pregnancy. ECT provides a discrete alternative to a longer-term use of medications and is seen to be less likely to harm the fetus. In the case of late-term pregnancies, it is often recommended that an obstetrician and a fetal monitor be available during the ECT procedure.

During the procedure of ECT the patient is hooked to a series of monitors similar to those used in modern medicine for any kind of anesthetic procedure. In addition to that we attach electrodes to the head to monitor the brain waves of the patient which is called the EEG.

The electrodes for the ECT stimulus can be applied in many ways. In our setting at Hillside Hospital, what we use and what most people find most patient-friendly, are the adhesive pads that are very similar to the ones we have all experienced when we get a cardiogram or an EEG. So from the patient's perspective this is merely two more sticky pads stuck to their forehead.

The placement of the stimulus pads that we use almost exclusively at Hillside is bi-frontal; both electrodes are placed on the forehead above the eyes. The current thinking for placing the electrodes frontally rather than at the patient's temples has to do with the belief that the frontal lobes of the brain are involved in the therapeutic process, and that stimulating the temporal lobes increases the cognitive effects. We know that we can markedly decrease the amount of memory loss and confusion, which is, still the primary problem with ECT, if we avoid direct stimulation of the temporal lobes. We call the new approach, Bi-frontal ECT which maintains the therapeutic results sometimes lost when Right Unilateral (RUL) ECT is used. RUL ECT keeps the electrodes further away from the left temporal area, but is not very effective unless it is given in very large doses.

The expectation generally, is that memory loss will be temporary. In our latest study, which compared bifrontal to bitemporal ECT, we found the memory loss was not very significant, even when bi-temporal ECT was used.

The primary use of ECT, and where it is used most often, is in patients with some form of major depression. With the symptoms of major depression, ECT is fantastically effective whether they have a psychotic component to their major depression or not. It is also effective with patients who are bipolar even when they are manic. It's used much less often there because of the difficulties in getting the patient to cooperate with the pre-ECT work-up, signing the consent forms, coming to the ECT area, and keeping themselves NPO (not eating and drinking before treatment).

It's also very effective in acute schizophrenia, however, in my opinion it is not more effective than neuroleptics. For the most part, most people treat acute schizophrenia with medications rather than with ECT, although ECT was originally developed to treat schizophrenia and is effective.

ECT is more effective than any other treatment in acute catatonia and, with one or two treatments, people will show remarkable changes from being mute and motionless to again being able to talk, move and start eating again. This is a critical milestone in these catatonic patients because the catatonia can be life threatening.

When treating patients with a clear cut diagnosis of major depression, ECT can be nearly 100% effective. In our study, which was reported in the American Journal January 2000, we treated 48 patients with 47 meeting all of our remission criteria by the end of the study. These were patients who had failed to respond to other modalities.

Another major ECT study we are doing focuses on maintenance ECT. Patients with major depression are treated acutely with ECT and then are moved to another phase where we study how ECT compares to medications for maintaining the patient. That study, which is still underway, involves our team here at Hillside Hospital, the Mayo Clinic, the University of Texas and the University of South Carolina, and has yielded preliminary data with about an 86-87% response rate.

When we treat other conditions like schizophrenia, even though the response rate is rather high, we don't succeed in the same way we do with depression in effecting remissions. I think many of our schizophrenic patients have improved considerably as they have been able to leave the hospital and live in group homes or move to a higher level of functioning…but I do not think we succeed in most cases in eliminating all the symptoms of their illness.

I believe that there are a lot of patients who are treated by people who don't have ECT available or don't think of ECT and these patients are treated much longer than need be with other modalities before turning to ECT.

In our present state of knowledge we still do not understand what are the underlying causes of depression. Hence, when we stop treatment of depression, we don't

See ECT on page 18

***Marshall Interview* from p. 1**

Q: Are the rates of PTSD the same for men and for women?

A: PTSD on the whole is twice as common in women as in men. Although it's not clear why that is, one possible explanation is that women are more likely to experience the most severe trauma—namely, sexual abuse or assault. Rape is one of the most severe trauma, and results in PTSD 50-70 percent of the time. And the vast majority of rape victims are women.

Then the last cluster of symptoms include *signs of autonomic arousal*, of which insomnia is often one of the most severe—but also irritability, jittery-ness and a heightened startle response.

Q: Is the startle response similar in ways to panic attacks?

A: No, it's not like a panic attack because it is in response to some kind of stimulus – usually sudden. It is a biologically based reaction that's actually been very well studied. And sometimes even when most of the other symptoms go away, the patient will retain their startle response for years later, which can be annoying at the very least. Recent research from Shalev's group shows that the startle response develops within 1 month in individuals who are developing PTSD.

So in review of the full syndrome, we are seeing the following: (1) Re-experiencing, (2) hyper arousal, and (3) Avoidance or Numbing. However, our recent study (due in the American Journal of Psychiatry in September 2001) is consistent with other studies from Murray Stein, Daniel Weiss, Charles Marmar and others, suggesting that *Sub-threshold PTSD* also carries considerable disability.

We studied about 9,000 people who came to National Anxiety Disorders Screening Day in 1997—and found that PTSD symptoms were linearly related to comorbidity, suicidality, and functional impairment, suggesting that in fact that a dimensional model rather than a categorical model might make more sense. So if you had three symptoms you were worse off then if you had two symptoms—and two symptoms were worse than one.

Q: Can you break down what you mean by sub-threshold PTSD?

A: A typical sub-threshold patient might have re-experiencing and hyperarousal but no longer be avoiding. In psychotherapy for example, you can help a motivated patient overcome their avoidance. Often the other symptoms will quiet down in treatment, but sometimes they won't. So that would be an example of sub-threshold PTSD.

Another typical example might be a patient who has re-experiencing and hyperarousal, but is drinking as a strategy of avoidance. It's not specifically described in the DSM as a manifestation of avoidance, but that's a fairly common scenario.

Q: Can you walk us through a typical unfolding of events for a person who experiences a trauma and then develops PTSD?

A: First let me say that there is a distinction between trauma and stress, which is very important because the psychiatric and the human consequences are quite different.

A Criterion A trauma (DSM terminology) involves a threat to the physical integrity of the self or others that has to be experienced, witnessed, or more rarely, heard about—with the exception of childhood sexual abuse. In that instance, even though there may be no overt threat, the fact that it is age inappropriate and coercive because of the power imbalance between the adult and child, can still lead to posttraumatic stress disorder.

The kind of typical traumas that we see are related to the violence and coercion that is very common in this country, namely: domestic violence, sexual assault, rape, childhood physical or sexual abuse, as well as automobile accidents, industrial accidents, or witnessing someone being shot or stabbed.

Combat-trauma is still most strongly associated with PTSD based on opinion polls, but actually the vast majority of people with PTSD in this country have PTSD related to other kinds of trauma.

The longitudinal course of PTSD is something I should comment on. Let's say a woman is in a serious automobile accident. Car accidents are the most common Criterion A Trauma in the US. About 1 in 10 that are in a serious car accident will get PTSD.

A normative reaction after a severe trauma can look somewhat like PTSD, meaning that the individual may have a heightened startle response, be generally anxious, have problems sleeping, and may re-experience the event especially when there are cues in the environment. For example, she might hear the screech of tires and suddenly get an image of the car accident from the week before. The next time she gets in the car she might feel extremely anxious and be generally more vigilant, more cautious – not just about cars, but about everything. This happens because there's a heightened, generalized awareness of potential danger in the environment after trauma. Considered from an evolutionary point of view, it might enhance the chances of survival when a more dangerous environment has been entered. Over time these reactions may fade away so that the images become less frequent and less intense. The individual is able to drive again without being anxious or without even thinking about the accident and the startle may fade away over a period of days or weeks. The trauma becomes a normal memory, which is accessed from time to time but does not possess the immediacy of the experience. It may have influenced an adjustment of behavior and assumptions about the world—for example, more caution when entering poorly marked intersections.

That would be a spontaneous recovery, and most people do recover spontaneously after serious trauma. We are fairly resilient as a species and we're normally equipped to have adverse experiences and learn from them, and are not debilitated by them in the normal course of events.

In contrast, somebody who develops PTSD will actually be getting worse instead of better - also, from the very beginning, the people who are going to get PTSD tend to have a more severe reaction and that's fairly clear - so that's sort of a clinical marker. If somebody is having an especially severe acute reaction to trauma, they are probably at risk.

Some of the other risk factors are known to be: previous exposure to trauma, having a psychiatric disorder, having a family history of psychiatric disorder, lack of social supports and the response of one's support system to the acute trauma. There's a pretty clear indication of genetic vulnerability as well, although with all the various biologic systems at work in PTSD, it is hard to say how the vulnerability is specifically manifested in the body. There are a couple of studies now that show that if people have low cortisol in the acute aftermath they are more at risk for PTSD.

Q: What is cortisol?

A: Cortisol is a stress hormone produced by the HPA axis (the Hypothalamic/Pituitary/Adrenal axis). Rachel Yahuda and others showed through a series of studies that at least a significant sub group of PTSD patients have low-normal cortisol at baseline as well as a more rapid decline in cortisol under stress or in the laboratory. This was a big surprise, because from the physiology most of us learned in medical school or graduate school, you would have thought cortisol would be in the high range. And the question there was: is this associated with PTSD or is it a pre-existing vulnerability? It looks like it's actually a marker for the people who are more likely to get PTSD—and was about 8% predictive in one recent study of stress hormones immediately after trauma. It isn't a lab-test for PTSD, though, because the predictive value is so low and it overlaps significantly with the normal range, but it suggests that there is something different in these stress responses.

I think at this point there is good evidence to say that there is some kind of a biological vulnerability that probably is not a single vulnerability. It is probably intrinsic to several of the biological systems that respond to threat and danger. One theory is that the threat response system fails to shut off, sort of like an alarm that goes off and keeps going off. There are a number of inhibitory mechanisms in the body, and in the brain, that are meant to shut down these biological systems, because they can be very destructive if they remain activated over an extended period.

These studies point to the theoretical rationale for the use of medications. It has been known for a while that psychotherapy can be very effective for PTSD and there are several psychotherapeutic approaches that work. What they have in common is that they are very supportive, provide education about the nature of the traumatic response, attempt to reduce feelings of guilt, shame, and failure surrounding the trauma, and focus on describing the traumatic experience in great detail. I think that it is actually the most dramatic and satisfying of treatments to conduct because you can see a remarkable degree of improvement in a relatively short time period.

Q: Has stigma played a role in the evolution of our understanding and treatment of PTSD?

A: I think that explains why we didn't get to it in the official nosology until 1980. There's always been a stigma in the military. Often soldiers with PTSD were labeled as treasonous and executed or discharged in a shameful way or put in military prisons. We see the same in the medical literature. There's a bias assuming that people with PTSD are always malingering, or are motivated by secondary gain. There is actually a syndrome in the early 20th century literature called "compensation neurosis." In the first DSM, the assumption was that if a patient hadn't recovered from the trauma, he probably had a personality disorder or some other kind of vulnerability to begin with. The notion used to be that "normal people are more resilient." Although vulnerability

see *Marshall Interview* p. 17

***Marshall Interview* from p. 16**

factors do exist as we discussed, they are not moral failings. We have to abandon these simplistic assumptions.

Q: Some of the literature suggests that people with a history of severe trauma and severe PTSD have been misdiagnosed, and incorrectly treated, as having schizophrenia or bipolar disorders.

A: This is a very important point. PTSD is under-diagnosed. The few studies in the literature found that trauma histories that relate to PTSD are missed as often as 90% of the time.

Why might this be? Patients are often ashamed or upset by discussing trauma, and the evaluators often do not know how to bring it up. Clinicians can be very uncomfortable asking about a history of sexual abuse or of rape or of the loss of a loved one. We are trained to help and so our instincts are to avoid topics that might be upsetting to the patient. But also, we avoid topics upsetting to us. We are getting better about it though. In New York State for instance, there is a requirement that there be an assessment of traumatic life events whenever a patient is admitted. The way to get the diagnosis of PTSD and assess for other possible consequences of traumatic experiences is to ask about specific traumatic events. If you don't do that then you're likely to miss it.

Q: Is the inquiry process even more difficult when you are dealing with children?

A: Yes. The manifestations of PTSD differ substantially in younger children, the process of evaluation is more subtle and inferential, and there are often serious social and legal consequences of a trauma history is elicited.

Q: What are some of the other diagnostic issues?

A: Subthreshold PTSD is an important issue. If a patient presents just one aspect of PTSD—such as an inability to sleep, irritability, and a heightened startle response—if you don't ask about recent life events you may not find out that this started after her spouse became violent at home.

If there is severe dissociation sometimes it's mis-diagnosed as psychosis. I have seen that on inpatient units where a patient with very severe PTSD and dissociation was mislabeled as schizophrenic and of course given the wrong treatment. Traditional anti-psychotic medications will make these symptoms worse in-stead of better. We have heard about patients who have been on inpatient units for years in the state hospital systems and never diagnosed or treated properly.

Q: If we want to offer hope to our readers—what can we say?

A: The overall message is that PTSD is very treatable and it appears that, unlike depression, patients who get better stay better. There is not a cumulative risk of relapse when treatment stops, and in fact several psychotherapy studies have shown that patients continue to improve after termination. I believe that in most cases, treatment facilitates a natural healing process, which allows patients to go on continuing to recover without our help.

A trauma focused therapy (and there are several that have been developed) should always be considered; otherwise you may collude with the patients avoidance. In order to get to that point, you often have to do a lot of education with patients as to why it's a good idea – and so you are trying to persuade the patient that facing the trauma rather than turning away from it would be helpful.

Medications can be an important part of stabilization and initial treatment if someone is really symptomatic. Sometimes a person will need a medicine before they can engage in the psychotherapy and occasionally you will see a patient who will completely recover with just the medication alone. I think it's rare and as our data suggests—automatic recovery will only occur 10-20% of the time.

A new study also suggested that people on an SRI (Serotonin Reuptake Inhibitor) showed gradual improvement over as much as a six month period. The best proven treatments at this point are the SRI's. There are several large multicenter trials that have shown that it works directly for the PTSD symptoms of re-experiencing, avoidance and hyper arousal. Now this is a very different model than what was believed even 10 years ago when medications were really just seen as an adjunct to the primary treatment of psychotherapy. Now we know that the medicines with supportive therapy can directly reduce these symptoms.

Q: So the SRI's that you refer to would be more commonly known by what name?

A: There are large multi-center trials with sertraline, paroxetine, and flluoxetine now, and sertraline has an FDA indication for PTSD. The paroxetine trial, which we hope to publish soon, was the first to show equal effectiveness in both men and women.

People should generally know that there are things other than the SRI's if the SRI doesn't work or if the patient does not want the SRI because of the sexual side effects for example.

Other medications you should probably *not* use without careful consideration is a benzodiaephine, because of the risk of addiction, although sometimes, patients do need it and it can be very helpful.

Q: Is there anything special that you would like to say to readers of Mental Health News concerning your work at the Psychiatric Institute and Columbia University here in New York, or about any research studies where you are seeking candidates to participate.

A: Yes thank you, this is very important…we have medication, psychotherapy and biological studies going at our center—and we treat people for free if they are participating in the research. Some of the studies also pay and we are always looking for new participants. Our main number is 212-543-5367.

for details on the studies
see the important announcement below

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Mental Health Internet Tip:

For more information about the New York State Psychiatric Institute, log onto their website at www.nyspi.cpmc.columbia.edu

Post-Traumatic Stress Disorder (PTSD)

The majority of Americans will experience a severe trauma during their lifetimes. Anxiety and fear are normal reactions after a serious trauma. However, when the reaction is severe enough, it can interfere with daily life, persist for several months or even get worse.

HAVE YOU BEEN EXPERIENCING ANY OF THE FOLLOWING?

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Post-Traumatic Stress Disorder

Who Gets PTSD?

Post-Traumatic Stress Disorder is a condition that can develop after a shocking, violent or severely upsetting event such as aggravated assault, rape, sexual and physical abuse, natural disaster or a serious accident.

Post-Traumatic Stress Disorder can affect anybody at any age. Recent surveys show that nearly 8% of Americans have suffered from PTSD.

Unfortunately, the vast majority of individuals with symptoms of PTSD never get help, even though new research has identified a number of potentially effective treatments

Treatment & Research

***FREE HELP** is available if you qualify, through a research program at Columbia-Presbyterian Medical Center and New York State Psychiatric Institute Research Foundation of Mental Health (RFMH). Dr. Randall D. Marshall is the Director of Trauma Studies at The Anxiety Disorders Clinic, which is funded through grants from the National Institute of Mental Health.*

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TRAUMA STUDIES PROGRAM

New York State Psychiatric Institute

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ECT continued from page 15

know if the person is going to become depressed again as soon as the treatment is stopped or whether they will go 15 years before they have another episode of the depression. We really don't know.

What most people do not understand is that ECT, like all the other treatments for depression, doesn't cure depression but rather reverses the symptoms.

When you look for a theoretical model for understanding how ECT works on the basis of brain and neurochemical functioning, we find that ECT like psychotropic medications, enhances or blocks the neurotransmitters such as serotonin, neurepinephrin, or dopamine.

There are a lot of people who oppose the use of ECT because, in general, ECT has connotations which are pretty horrendous: electric shocks are thought to cause very uncomfortable sensation, and the whole notion of giving a person a convulsion, sounds barbaric to the average person. Also, in the early days of ECT, some people thought that memory loss was a necessary aspect of the therapeutic process, thus, many patients were given excessive numbers of treatments to maximize the memory loss. For these patients the results may have indeed been toxic.

Many times people will ask me what about the people who insist that ECT has ruined their life and destroyed their memories? My answer to that question is that although I am concerned when I hear that response, I feel that these people very much represent a small minority of the patients, compared to the great number of patients who have benefited from ECT.

We treat very many patients here at Hillside, and most patients have virtually no complaint of memory loss. One kind of memory loss complaint which is very hard to evaluate is difficulty recalling someone's name, where we went on vacation at a certain time or who was in that movie or who wrote a book we read recently. When we can't recall such memories it is very annoying because it is something we feel we should know. People who have had ECT tend to attribute these kinds of lapses of memory to the ECT and there is no way of objectively measuring these types of complaints. I myself would probably also attribute and blame ECT for such a lapse in memory, had I had ECT, to explain such occurrences, just as these people commonly do. I think this happens a lot and many patients will say since I had the ECT my mind is a sieve—I keep forgetting these things.

Dr Bailine is the Physician-In-Charge of the Hillside Hospital ECT Program. This is one of the leading ECT programs in the US and perhaps, the world. It is one of the largest clinical programs (doing more than 3600 treatments per year), it also has a highly respected research program and a teaching program which includes a 5 day certificate course to train psychiatrists to do ECT.

Publisher's Note

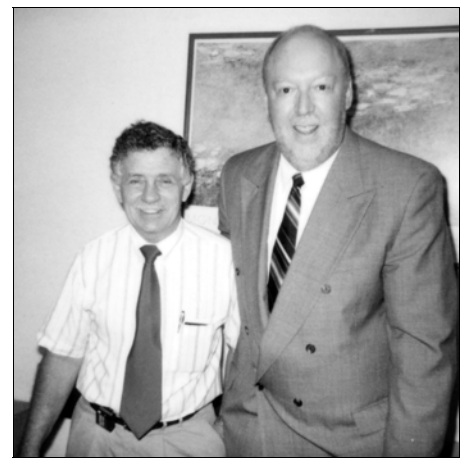
It was with great pride and appreciation that I had an opportunity to work with Dr. Bailine in bringing this article on ECT to you.

I realize that ECT is a controversial treatment, nonetheless, I credit it for saving *my* life following ten years battling major clinical depression.

Mental illness is being accepted and talked about more openly than ever before, however, many people feel that it is their duty to malign ECT as barbaric and a treatment that destroys minds rather than heals them.

Certainly, many approaches which medicine brings to patients in illnesses from heart disease to cancer have in some instances less than beneficial outcomes. Should we therefore discontinue therapies which in most cases save lives?

The mission of Mental Health News is to bring information, education and advocacy to the community. This is the first time that we have delved into the topic of ECT, and I suspect that it won't be the last.



Ira Minot visits Dr. Baline at the ECT Lab at Hillside Hospital on Long Island

Many people have had great success in overcoming serious mental illness as a result of ECT treatment, however, stigma prevents many from coming forward.

Mental Health News wishes to invite courageous survivors to share their story by contacting me directly. Thank You.

Ira Minot

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Music… A Window To The Soul !

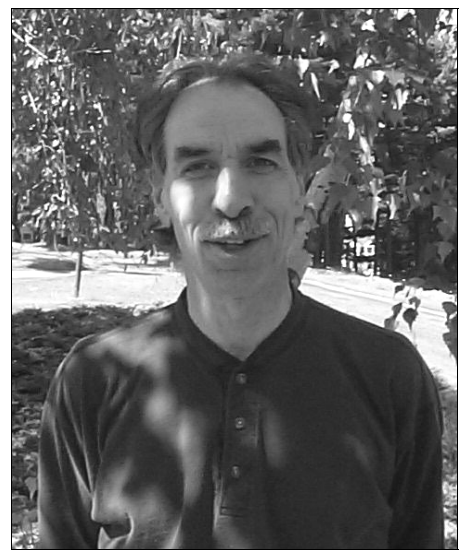
Music Therapy and Mental Health

Have you ever listened to a song and suddenly remembered something from long ago? Something happy, something sad, something you'd once longed for but since forgotten? That is the wonder of music. If it is a new tune, or something from the past that starts the memories flowing, music is the magical medium that evokes an emotional response in almost everyone. Whether it is the feeling of familiarity, security, or something more toward the other side of the spectrum, like trauma, the sensory stimulation of music is an avenue of experience that enables the therapist to reach even those who are resistive to other treatment approaches. The other side of the coin, of course, is that it can be a source of pure pleasure, especially in young children who have no negative associations to the world of music, but, simply enjoy the beat!

At Four Winds Hospital, "music is used therapeutically as a powerful and non-threatening adjunct to treatment," says Doug Malfer, Assistant School Administrator at the Four Winds on-grounds school, The Learning Center, and the resident pianist. "The power of music reaches much farther than just the music itself," he explains. "Children who are struggling to read can hear the words, often memorize them and then see them on the paper in front of them making an association between the words they 'know' as they sing and the words they see on the paper—it helps them to read the words. The act of singing itself is a great release and can be an excellent way to build self-esteem. In addition, we 'salt' didactic songs into the popular music that they can identify with so that the experience is also one of learning. Songs like, *Lean on Me, You've Got a Friend*, and other such songs that convey messages of hope, friendship and support."

The musical talents of the Four Winds staff involved in the music program, both instrumental and vocal, are utilized to facilitate changes in the children that are non-musical in nature. The children become involved in singing, listening, moving, playing and in creative activities that assist them in learning new skills and honing others. As members of a multidisciplinary team of clinicians, the music therapist's feedback will assist the team in assessing the emotional well being of the child, social interaction, communication skills, and cognitive reasoning through musical responses. Along with learning the words to songs and singing them, the children are taught to use musical instruments to accompany the piano and guitar players. How the children respond during their participation in these groups can be indicative of their self-awareness, confidence, coping skills and pro or anti-social behaviors. Working with musical instruments also assists the therapist in evaluating the fine-motor skills of a child, not to mention the obvious - their hidden or evident musical talent!

Research data and clinical experiences attest to the viability of music therapy as treatment for a full range of mental illnesses. The efficacy of the effects of music therapy are punctuated by the fact that Music Therapy, as a related service, is even included under the Individuals with Disabilities Education Act. It is also recognized as a viable treatment modality by the Centers for Medicaid and Medicare Services (formerly HCFA), and the Joint Commission on the Accreditation of Health Care Organizations (JCAHO), among others.



Doug Malfer

What is Music Therapy?

As defined by the nationally-known American Music Therapy Association, "music therapy is an established health profession similar to occupational therapy and physical therapy. It consists of using music therapeutically to address physical, psychological, cognitive, behavioral and/or social functioning. Because music therapy is a powerful and non-threatening medium, unique outcomes are possible." With young children, music therapy provides a unique variety of music experiences in an intentional and developmentally appropriate manner to effect changes in a child's behavior and facilitate development of his/her communication, social/emotional, sensory-motor and/or cognitive skills.

How Does Music Therapy Make a Difference With Young Children?

- Music stimulates all of the senses and involves the child at many levels. This 'multimodal approach' facilitates many developmental skills.
- Quality learning and maximum participation occur when children are permitted to experience the joy of play. The medium of music therapy allows this play to occur naturally and frequently.
- Music is highly motivating, yet it can also have a calming and relaxing effect. Enjoyable music activities are designed to be success-oriented and make children feel better about themselves.
- Music therapy can help a child manage stressful situations.
- Music can encourage socialization, self-expression, communication, and motor development through movement.
- Because the brain processes music in both hemispheres, music can stimulate cognitive functioning.

Along with the obvious therapeutic value of music as a tool in working with children, in a multicultural environment such as Four Winds Hospital, music serves to build a spirit of community, crossing all cultural lines. After all, music is the 'universal language.'

Four Winds Hospital is the leading specialized provider of child and adolescent mental health services in the Northeast. In addition to the Child and Adolescent Service, Four Winds also provides comprehensive inpatient and outpatient mental health treatment services for adults, including psychiatric and dual diagnosis treatment. Incorporated into the daily schedules of each patient are expressive and creative arts therapies. These serve to enhance traditional therapy while opening different avenues of expression. The articles contained in this newsletter will offer a glimpse of these adjunct services.

Art Therapy: What is the Clinical Target?

The Art Workshop at Four Winds Hospital provides patients with a safe, non-threatening environment where art is used as a means for developing a patient's self-awareness, increasing self-esteem, and as a recreational tool for individuals to explore and express their emotions through process-oriented therapy.

Ker Beckley and Ron Crowcroft

"The process of creating is as important or more important than the end product," says Ron Crowcroft, Director of the Art Workshop at Four Winds. "The process of creating art also includes learning appropriate social communication and coping skills. These would include planning, time management, frustration tolerance, proper use and cleaning of materials, appropriate conversation and verbalization, such as no swearing, not talking negatively about peers, relatives or staff, not putting down the work of another individual, keeping conversation volume down to an acceptable level where everyone can be heard without shouting, clear and appropriate requests for help, etc. Patients are also here to re-create situations or feelings from their lives that may offer healing and motivational insights through the use of a different medium than what they may be used to in order to test their concentration and coordination skills, learn new ways of developing a positive self-image, and also just to have for its own sake, an often difficult lesson to learn," says Crowcroft.

While maintaining a "normalized" setting during their visit to the Art Workshop, patients are afforded some control over their immediate environment by being given choices of projects, colors, mediums, etc. Simple organizational skills are reinforced as patients are asked to select, gather, and then 'put away' whatever supplies they've chosen to use. Many, particularly the children, have not known much structure in their lives and these simple exercises reinforce their skills. The use of limit-setting and boundary-maintenance techniques are reinforced so that individuals come to know what is, and is not acceptable in a recreational/social group—a lesson that they will take with them upon leaving Four Winds, and use in many other ways in their daily lives.

Limit-setting in a creative art therapy session includes the reinforcement of various skills, not the least of which is to complete one project at a time. This technique assists patients in working through their problems rather than giving up when faced with a difficult issue, or 'unsolvable' problem. The creative art therapist is there to help them and support them through to the completion of the project. As an adjunct service to traditional inpatient treatment, for many, this is important therapy, because it affords the patient the opportunity to take home a physical reinforcement of their progress, in the form of a completed project.

Ker Beckley, clinical art therapist at Four Winds Hospital explains that art therapy is a "nonverbal avenue for communication." "Patients are introduced to new avenues of expression through art therapy. The creation of something with clay, painting, sculpture, pencil, ceramics and all of the various mediums that are made available to the patients here are tools for self-expression." says Beckley. "Art therapy is a metaphor for life. As a problem arises, each individual is encouraged to work through the problem to a solution, a completion. The intention is to create problem solving skills through the process, increase frustration tolerance, and to integrate this new knowledge into all aspects of life," she says.

Children's Art Expresses Their Pain

With 145 inpatient beds exclusively for children and adolescents at Four Winds Hospital, art therapy has become a tremendous asset to inpatient therapy. Children find tremendous release, are able to express their feelings, and very often 'tell their stories' through the experience of creating art.

"Children speak to us through their art," says Janet Z. Segal, Chief Operating Officer at Four Winds. "Art is a clinical tool that enables children who can't verbalize their feeling to tell us what is troubling them. Their drawings are visible expressions of that trouble. Art therapy is a way of understanding something about somebody else – it is not about the 'art' itself, it is about children being given the opportunity to bring forth the root of their pain", she says. Ker Beckley agrees. "In viewing these pieces, it is important to take note of the choices of color, the scale of work within each piece, the 'hidden messages' in a piece of art, a not-too-obvious expression of something much deeper. When you look at this work, you are entering into a conversation with a child. This is a vehicle for understanding what is happening inside of them, a simple tool that the child can use to express not-so-simple feelings." Indeed art therapy is a very telling modality for expression. The collaboration between the art therapist and the rest of the clinical team can accelerate recovery, particularly with children.

A Benefit to All

Learning to create something of your own, very often for the first time, can be intimidating, exciting and rewarding. Many children, adolescents and adults have never been exposed to the creative arts and come to find that they have built confidence in the area of self-expression. Art is also an excellent alternative to otherwise unproductive and destructive leisure activities.

Art therapy can evoke feelings of rebelliousness, anger, frustration, and all manner of emotions and yes, it is addressed as part of the patient's treatment—including the limit-setting over what is and is not appropriate in a variety of settings within the hospital and thus in the larger world to which they will return after discharge. Many patients need to modify behaviors, and develop new copying skills, and new ways to channel anger and other emotions. They also need to be taught self-limits, and within a structured setting, they can more easily do that and be more creative (knowing what the rules are in the art therapy workshop and throughout the hospital.)

The success of art therapy, a component of the comprehensive inpatient care at Four Winds, is the easiest to *see*. Progress pictures are kept by the art therapists, and one can clearly see the healing in a visual journal.

Upon admission, a 13-year old psychotic child was asked to draw a picture of an apple orchard. His choice of using one color, black, for the entire picture, and drawing random, endless lines seemed unrecognizable as anything but scribble to the untrained eye. To the art therapist, however, it was the beginning of this child's story as his journey through Four Winds began. Periodically, the child would be asked to revisit the original task.

These drawings reflected the patient's progress in treatment with improved cognitive awareness, and control of thoughts and impulses as compared to the original picture upon admission. Just prior to discharge the child was asked to create another drawing. Along with a general consensus of wellness from the multidisciplinary team, the art therapist was able to add that the child's final drawing showed an increase in organization and self-expression, enhanced organized thinking illustrated by his ability to draw trees with apples in them, versus the random scribbles submitted upon admission. Clear progress had been made within the context of this patient's individualized treatment goals.

Psychodrama and Body-Mind Awareness

Psychodrama and Body-Mind Awareness Groups at Four Winds Hospital are alternate therapies that allow for the expression of emotions through an avenue other than 'talk' therapy.

Psychodrama is a method of exploring, through actions, the worlds in which we live—both internal and external. It allows for the safe expression of strong feelings, the development of insight, and a wider perspective on individual and community problems as well as the opportunity to try out new, desired behaviors.

During a psychodrama group, members re-enact scenes from their lives taking on various roles for one another. Growth and healing happen with the working through of situations. Rebecca Walters, M.S., a trainer, educator and psychodrama practitioner (TEP) certified by the American Board of Examiners in Psychodrama, Sociometry and Group Psychotherapy is the Director of Child and Adolescent Psychodrama Services at Four Winds Hospital. "By re-enacting key moments and important issues, and by putting a child's inner most thoughts and feelings into actions, with the help of group members, psychodrama can assist the child or adolescent in experimenting with new and more satisfying behaviors and roles in their personal lives," says Walters. "They find emotional release by experiencing the safe expression of strong feelings and develop insight into their lives, behaviors and feelings, while learning social skills and new ways of relating to themselves and to others." "Because it is so highly visual, it engages the children in a way that talk therapy is sometimes unable to," says Walters. "Psychodrama is a form of play, and children explore their worlds through play. Children often reveal things in psychodrama that they are unable to verbalize, but they are able to 'show' us through this avenue of therapeutic expression."

Psychodrama is also used in adult group settings at Four Winds and is conducted by Judy Swallow, M.A., TEP. "In a psychodrama group, adults explore their pasts, their present situations and look into the future all as corrective experiences." This therapeutic method requires a protagonist, auxiliary egos (group members who assume the roles of other people in the protagonists life,) an audience (other group members who observe and react to the drama); and a director (the therapist). The protagonist selects an event from his or her life and provides the essence of the original experience so that it can be re-enacted. Techniques used in the psychodrama may include role reversal, doubling, mirror technique, future projection and dream work.

Body-Mind Awareness

Adapted from techniques used in the Rubenfeld Synergy Method of releasing emotional and physical stress through body movements, the Four Winds Body-Mind Awareness Group is used with adults to assist them in becoming aware of how they are breathing, and using, or not using their breathing to assist them in working out tensions—how to use their own bodies, to become aware of the grounding qualities that come with feeling one's feet on the ground and sensing how one's own spine gives support.

In creating a safe, comfortable environment in which to explore oneself physically from the inside out, this experience allows individuals an avenue in which to release the 'pre-bundled' physical stress responses that they have been carrying around as well as their emotional stress. The seminal difference is teaching people to *know the difference between tension and relaxation,* and giving them the tools to first recognize, and then relieve the physical tension whenever they need or want to relax.

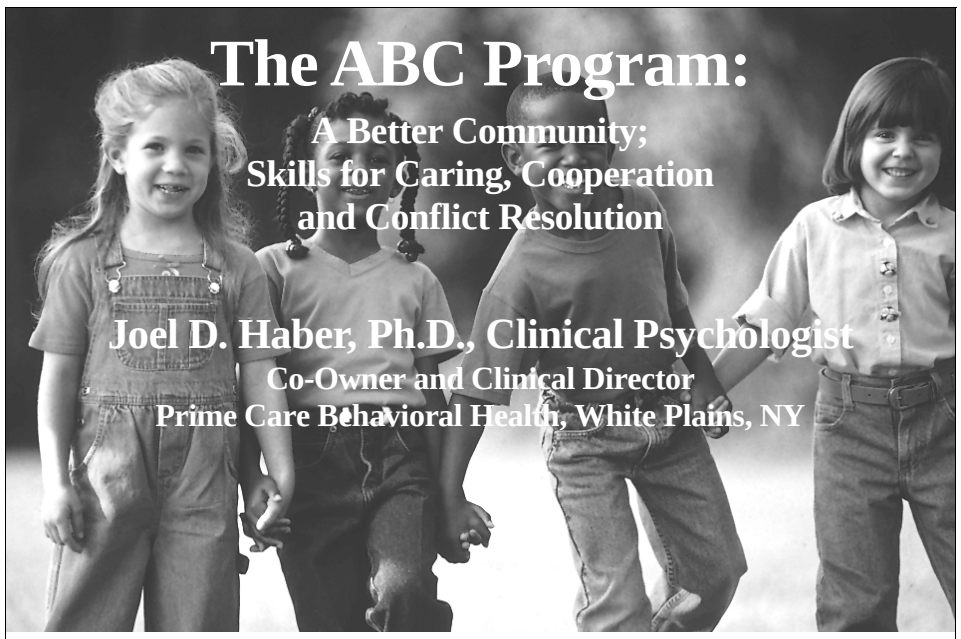
So, what is actually happening during a body-mind awareness session?
Changing habits of body movements, breathing patterns and thought processes are all by-products of body-mind awareness. Anecdotal reports from patients involved in this therapy have included improvements in self-esteem, body image, depression, head and joint aches, spinal cord, neck and shoulder tension and a change in creativity and self-expression. In a guided journey combining the elements of touch (feeling the floor, expanding your fingers) and talk, access to the emotional and physical connection is gained, and the individual experiences whatever is happening 'at that moment' thereby opening an avenue to use intuition and self-care in daily life. Attention is paid to posture, maintaining personal boundaries and conscious breathing. By teaching the body and the mind to 'read one another' there is a lessoning of anxiety, a sense of well-being, a knowing that a 'bad feeling' (physical or emotional) may be a prodrome that can be headed off at the pass.

Judy Swallow, a Master Synergist trained in the Rubenfeld Method, and a member of the multidisciplinary team at Four Winds Hospital, began her career when Ilana Rubenfeld, the founder of the Rubenfeld Synergy Method, offered her first professional training class in 1977. "Ilana played many roles in the Rubenfeld Synergy class" remembers Swallow. "She rented a house on Long Island where we formed a community and worked together very intensively with Ilana as the administrator, personal trainer to each trainee, and supervisor. It was a wonderful journey, an intimate exploration for each of us, a 'first', and I think that we were all aware that we were part of something very special."

"Twenty four years of clinical experience has taught me that people come to these groups with many negative experiences that have hindered their ability to trust, 'open up' and learn new things", says Swallow. "It is my job to make each person feel safe and supported within the group setting, and to allow their sense of mutual expectation and anxiety at 'trying something new' to work for them as a positive."

In explaining further the benefits of combining a body-mind awareness group as an adjunct to traditional inpatient mental health treatment, Swallow evokes a few of the Principles and Theoretical Foundations of The Rubenfeld Synergy Method on which she, in part, bases her work. "In this group setting, individuals have the opportunity to explore alternate choices and to develop possibilities for emotional, physical and psychophysical change. Awareness is the first key to change, bringing the unconscious into awareness. Individuals may experience memories of the past, and think about their future, but change itself can only occur in the present," she explains, "and the ultimate responsibility for change rests within the individual." People are not forced to make changes, but rather, taught to recognize dysfunctional behavior in themselves and guided to try new behaviors, taught to recognize habits that have not been helpful, and steered toward learning new ones.

Recognizing feelings of pleasure, lightness through laughter, envisioning a beautiful, peaceful place, or envisioning a change in yourself or your situation are all places that an individual, who might otherwise be unable to allow themselves such self-expression, are able to go in a body-mind awareness group. A place that is away from the pain, the grief, or the sadness that has brought them to an inpatient setting in the first place.



Friday, December 7th, 9:30 - 11:00 am

To register and/or to receive a free copy of our Educational Events Calendar, please call 1-800-546-1754, ext. 2413

Fee: $20.00 payable to the Four Winds Foundation
Registration Required

Priscilla L. Vail, M.A.T., Learning Specialist, Consultant, Author, Bedford, NY

Friday, October 19th • 9:30 - 11:00 AM

To register and/or receive a free copy of our Educational Events Calendar, please call 1-800-546-1754, ext. 2413

Fee: $25.00 payable to the Four Winds Foundation
Registration Required

The Four Winds Learning Center - Teachers Tie It All Together

Reading, Writing, 'Rithmatic and more! That is the daily challenge faced by the masters' level and special education teachers at Four Winds Hospital. At The Learning Center, the hospital's on-grounds school, teachers provide individual instruction to children and adolescents who are currently undergoing inpatient, or outpatient partial hospitalization treatment. Depending on the emotional and/or physical capabilities of the child or adolescent on any given day, the 1-1/2 to 2 hour (5 day per week) educational component includes the four basics, English, Social Studies, Math and Science, as well as an opportunity for the children to practice the various skills and tools that they have been acquiring in the creative, and expressive groups that they participate in as part of their daily therapy outside of school.

Building a 'literal' rainforest out of paper with a large forest canopy, monkeys and snakes hanging from "trees," brightly-colored macaws peaking from behind giant palm fronds suspended from the ceiling, and a myriad of magical practical experiences incorporate and reinforce skills developed in social skills groups, art therapy groups, and others. Cooperative planning exercises include constructing the rainforest, transforming the school into a Native American Indian reservation complete with totem pole, "raising" caterpillars and releasing them as butterflies, and singing songs relevant to the topics at hand.

Along with the creative activities that most consider the 'fun' part of their school time, there is also the serious business of study.

The Four Winds Learning Center, a self-contained classroom setting, has the smaller children enjoying classrooms decorated in bright colors, individual 'cubbies' decorated in primary colors, miniaturized chairs and desks—all consistent with elementary school décor. The adolescents join their teacher at an oval table surrounded by four chairs and the décor is similar to that of a middle school and/or high school setting. Each room has it's own computer, and the science lab is fully equipped. Each cottage where the children or adolescents reside has its own homeroom teacher who is assigned to coordinate the academic curriculum for just those 15 children. Individual instruction is given in even smaller groups while the other children in the cottage participate in an alternate activity/therapy.

Four Winds Hospital, the leading provider of child and adolescent mental health services in the Northeast sees more than 1500 school-aged children pass through it's doors each year ranging in grades from K – 12. As an acute mental health treatment provider, their stay at Four Winds is not long, and therefore their abbreviated study time here is challenging. Recognizing that the children and adolescents are here due to a primary mental health issue - education, while vastly important and incorporated daily into their schedules, is achieved only when it fits into the individualized treatment goals on any given day. At Four Winds, the specially trained teachers face the challenge of teaching a day of school work in 90 minutes, while reinforcing social and limit-setting skills, and supporting students through their individual psychological issues. New York State Regents exams, New York State mandatory exams, and individual finals from area schools are given, as required. The Four Winds Learning Center's School Administrator, Barbara Kurian says, "With 14 teachers, teaching 1500 children from 1200 different schools from primarily three states, New York, New Jersey and Connecticut, we are always on the go. Streamlining communication between Four Winds Hospital and the child's home school is essential to a smooth transition. Organizationally, these are the steps that afford the child the most "seamless" transition into the hospital and the most efficient reentry back into their individual schools," says Kurian.

Barbara Kurian

- When a child is admitted to Four Winds Hospital, and parental permission is granted, the Four Winds Learning Center contacts the home school (typically a guidance counselor or person designated by the school to be the 'official' school contact for this child) and they are informed that the child is hospitalized and will be attending school as part of their course of treatment.
- The school contact is asked to forward information on what the child is studying in the four basic categories of English, Social Studies, Mathematics and Science by *topic*—as opposed to a specific chapter or page in a book. Four Winds teachers are completely familiar with New York State curriculum and widely versed in curriculum requirements for the tri-state area.
- While ever effort is made to accommodate the requirements of each of the 1200 individual schools, completing individual assignments for individual teachers is often unattainable due to many factors, not the least of which is the fragility of the child, the short length of stay (sometimes assignments arrive post-discharge!) and the volume of patients moving through the school so quickly during the day.
- Each patient is given individual instruction in the topics that are provided to the teachers and they are graded on a pass/fail, or letter-grade basis as they are discharged. This information is then given back to the primary contact at the school, and included in a discharge summary, so that the transition is complete and comprehensive.

"The children benefit greatly by the individual attention and self-contained quiet spaces," says Kurian. "The success of the students who have passed through the halls of the Four Winds Learning Center is never more evident than when they are here during mid-term, finals week, or after a student has mastered a topic that they had been struggling with in their mainstream classroom. Success on those exams, a palpable improvement in self-esteem, a sense of gratitude to their individual instructor and a self-knowledge of great accomplishment, as witnessed by their broad smiles, says it all at the end of the day!"

Finding A New Life Free From Domestic Violence Took Courage And Help From The MHA of Westchester

By Janice Munson
In Her Own Words From A Speech Given at the MHA Annual Dinner

When I first came to MHA for help—as a victim of domestic violence – I was terrified. It was hard to come forward and acknowledge what was happening to me. Rather than telling me what to do—that I should leave a marriage in which I was regularly beaten and constantly diminished—the clinicians at MHA listened to me and treated me with respect and dignity.

My feelings and thoughts were validated. And they told me a few things, starting with something I'll never forget: "No one has the right to hurt you."

I'd like to tell you about my first visit—the day I showed up without an appointment. But let me back up first with a little information about where I came from.

During more than 12 years of marriage, I hid the fact that I was battered. Ironically, I was a newspaper reporter in a Midwestern city and wrote extensively about non-profit organizations that help people. My husband was a business executive. Early on, I had misinterpreted his intense possessiveness and jealousy—both warning signs of abuse—as expressions of love.

I was vulnerable…unsuspecting…and then found myself trapped in something I didn't know how to get out of.

There were days I could not go to work because the injuries were too severe. And the verbal and emotional abuse was just as debilitating.

When we relocated to New York, I thought things would change but the problem traveled with us. I now became totally isolated. I learned to stay quiet and watchful and to suppress my opinions and emotions. I was given a small weekly allowance. He now had complete control of the finances.

Eventually, I became unemployed…I was devastated but unemployment turned out to be fortunate.

At home, with time on my hands, I made friends with a woman in my neighborhood.

One day, when I showed her…bruises around my face and neck from having been strangled the night before…she stopped being a sensitive listener and urged me to get professional help.

Her nudge got me to MHA that day. When I stepped into your lobby, I asked the receptionist, Sylvia, for information on domestic violence. My plan was to take it and leave. She asked if the information was for me, and I nodded "Yes." Sylvia suggested I take a seat and wait.

It wasn't long at all before a woman appeared and invited me into her office. Beverly Houghton let me talk myself out before she began telling me how to protect myself.

I took notes. She told me to destroy the notes before I got home. I knew then that she knew what it's like to live with a batterer—that survival is everything. I felt safe with her.

I agreed to come back next week for another appointment. We arranged my weekly fee at $8. It was the best I could do at that time.

At my next appointment, Beverly said there was a new therapist I would be seeing. That didn't feel good but I returned and met the new person, Jennifer Brennan. We got through the first session okay.

She used a word I had forgotten the meaning of when she said, "You have options." We talked about the choices before me. She also said something I would hear a lot of: "It's not your fault."

At a subsequent session, she reviewed my treatment plan with me and sought my approval. I liked being asked what *I thought* was best for me. The first objective was that I would not be hit again. The second was that I would improve my self-esteem. I thought that sounded pretty good. And by the way, I never was hit again. But I'm still working on the self-esteem, which is getting better.

At home, I picked the right moment to tell my husband I was in therapy and to suggest he might want to go as well…because things needed to change.

I don't know where I found the courage to even broach the topic with him. It was as if the sessions at MHA had given me a source of strength I had not been able to tap into. I was no longer alone with the silence.

He denied there was a problem and warned me not to talk about him with anyone.

It was time for me to get out. Fortunately, I began working part-time at Philip Morris's office in Rye Brook. This boosted my morale. It also brought the financial independence I would soon need.

The day I walked out of the marriage, I took very little with me and left a brief note behind on the dining room table.

I was diagnosed with posttraumatic stress disorder—which explained the severe anxiety attacks, flashbacks and nightmares I was experiencing. I learned at MHA how to cope with this as well as the harassing phone calls I was receiving at work from my husband.

I continued the weekly sessions with Jennifer, who reassured me that my ambiguity and fear during this period were understandable. I had someone who was actively listening, whose eyes were filled with compassion whenever I cried, and someone who gently guided me through a very dark period.

And I had someone who was encouraging me to express my feelings…and praising my accomplishments, no matter how small. One day Jennifer leaned forward and said, "You are a very capable woman." For someone with a low sense of self-worth, this was like magic. Eventually, I would believe it myself.

I stopped therapy for nearly a year but returned when I was grappling with difficulties in my interactions with people, particularly an inability to make my feelings and wishes known. I couldn't say the word, NO. I was timid and felt un-entitled.

In addition to current situations, I also looked at the past and explored those areas that were painful but that needed to be brought out into the light.

Jennifer led the way with questions I sometimes didn't have answers for…but we kept chipping away at a number of subjects, some repeatedly.

I had the opportunity to serve on MHA's Survivors Advisory Committee. Betty McCorkle and Francine Rosenthal wanted our input on their project plans. They called us survivors, the Experts.

My life was being enriched. In therapy, if I'm not mistaken, I was now determining what the focus would be. We established projects with specific goals and timeframes. I wanted feedback and received it.

One day, we observed that we were laughing a lot of the time. I complimented Jennifer on the good work she was doing. She insisted that I was the one doing all the work.

I was given so much, I wanted to give back. Last year, I graduated from Fordham with a Master's in Social Work.

Recently, I joined the board of a not-for-profit organization in my neighborhood.

I'm now working full-time at Philip Morris and proud that my sister company, Kraft Foods, is being honored tonight with MHA's Community Leadership Award. And congratulations to tonight's co-honoree, the Bank of New York.

Since taking a new job at Philip Morris in the city, I haven't been able to continue therapy. But I know there will always be an open door at MHA.

Every day, I carry with me something of great value and that's an understanding of the importance of relationships based on respect, trust, honesty, kindness and care. Those words describe the environment I found at MHA and that came to life in my sessions with Jennifer. She does, indeed, do a lot of good work. So does everyone here in this room tonight.

Thank you.

The Brain Medicine Show

Staff Writer
Mental Health News

The Brain Medicine Show is a weekly radio program dedicated to the education and advocacy of mental health issues. Co-hosts Drs. Joseph Deltito of Greenwich, Connecticut and Jay Lombard, of Nyack, New York, psychiatrist and neurologist respectively, discuss mainstream medicine and bring up-to-date information on the diagnosis and treatment of psychiatric disorders to a wide audience.

Q: Dr. Deltito, tell us about your new radio show.

A: The title of the show says it all incorporating aspects of neurology and psychiatry. The Brain Medicine Show came about when WEVD (1050 AM – Sundays from 7-8PM) contacted Dr. Lombard about doing the show – GNC (General Nutrition Centers) was the original sponsor. The show can be heard all over the metropolitan area.

Mental Health Talk Radio goes back many years, and there are people around the country doing medically oriented shows but the vast majority are doing poor shows which in my opinion are doing a disservice to patients. Many of the Doctors on these shows are people who would pretend to be doctors, pushing unproven treatments with substances that they themselves make and sell. So many of the medical shows that are out there are essentially infomercials, and many people are pushing unproven herbs and nutrients where there is no science behind them in helping people with any aspect of medicine.

Now we're not anti-nutritional supplements as you can tell, because my co-host Dr. Lombard is an expert in this area, and in fact, one of our sponsors is GNC. On The Brain Medicine Show, we're talking about how different things may be used in combination with traditional medicine. We're saying "where does a particular supplement fit in reasonably within the choices that we have for people that have serious illnesses."

Our bottom line is that we want to be a voice against those other people on the radio because we don't want people with serious mental illnesses like schizophrenia, obsessive compulsive disorder and bipolar disorder to not get effective treatment.

Any one, therefore, that thinks that the primary treatment for schizophrenia is Yoga should be shot, because they may actually induce people for a long time not to get the proper medicine that allows them to get on with their life or prevent suicide or homicide and things like that.

We hear a lot of people who have, what sounds like severe depression who talk to us about taking treatments which we would expect would do nothing or may actually do harm to patients.

Manganese is something which came up on the last show which Dr. Lombard knows to be a neuro-toxin if taken in high dosages. The question remains is why are people taking these things instead of standard treatments? Certainly, there may be some sense if people have failed standard treatments, but you have to be suspect with any doctor who starts with some vitamin regiment or nutritional regiment first for people who have severe mental illnesses.

Q: What's your hunch—is there a general distrust for Psychiatry today?

A: I think there are some people who feel like there is a stigma issue and they are not seeing real psychiatrists or they have in their mind that if they take Prozac or Zyprexa or Depakote that then they really are crazy. Sort of like a self-stigma—but if treated themselves with some vitamin preparation—then they're really not crazy; they are not really stigmatized but rather have a little bit of this or that ailment...instead of the whole notion of a mental illness being destigmatized as it should be and people just going to the doctor and getting rational treatment as they would with any other illness. That's the idea behind the name of our show, The Brain Medicine Show—because we're talking about brain conditions and getting people help in this particular area as they would for cancer or diabetes.

Drs. Joseph Deltito and Jay Lombard

We combine neurology and psychiatry on the show because there really isn't a distinction between Alzheimer's disease and Schizophrenia in the sense that one's a brain disorder and one's a mind disorder. That's an artificial distinction.

Some of our sponsors so far are GNC, Westchester Medical Center and Eli Lilly. In addition, one of our sponsors is Manero's Restaurant in Greenwich.

Certainly, I would urge everyone to support *Mental Health News*, and tell you how proud we are of what you are achieving with the newspaper...and that we urge people to tune into the Brain Medicine Show, which by the way, will be switching to a new station in the coming months. But we will let everyone know when that happens.

Posttraumatic Stress Disorder As Normal Adaptation

By Andrew P. Levin, MD
Medical Director, Westchester Jewish Community Services

As psychiatry develops new techniques to evaluate and treat mental disorders, we continue to explore their origins. In a previous article I discussed anxiety disorders from the perspective of evolution, conceptualizing anxiety disorders which disrupt function as exaggerations of normal and adaptive anxiety. A similar approach is useful in understanding PTSD for both the clinician and the patient. The general principle is that the disruptive responses which comprise PTSD have some usefulness in less exaggerated and less persistent form. The current diagnostic criteria recognize this principle, specifying that symptoms that persist for less than a month are labeled "Acute Stress Disorder" whereas Posttraumatic Stress Disorder is diagnosed when the symptoms persist for more than a month.

How then are the symptoms of PTSD adaptive? By definition, PTSD starts when the individual is confronted with an overwhelming, life-threatening situation. Over the course of evolution, organisms have developed strategies for coping with threats to survival. A normal response to a life-threatening situation is extreme fear followed by either flight from the danger or freezing. If you have ever caught a deer in your headlights, you have witnessed the freezing response. Similarly, many survivors of trauma tell us that they were frozen with fear when assaulted or attacked. Flight is an obvious effort to escape the danger, but how could freezing be adaptive? Confronted by a more powerful and stronger predator in the wild, freezing may have evolved as a safer response than flight which could alert the predator to the prey's position. Helping the survivor recognize that freezing is an automatic, reflexive response when confronted with an overpowering assailant can ease the guilt and shame victims feel when they recall that they did not flee or resist their attacker.

In the days and weeks after a traumatic experience, survivors repeatedly play the events over in their minds. Often the thoughts intrude during waking hours, sometimes becoming a "flashback," a vivid re-experiencing of the trauma which evokes the same fear, flight, and/or freezing that occurred when the trauma was first encountered. These repetitive experiences might be understood as a form of rehearsal. It's a safe bet that in the wild predators will return to threaten again (they don't stop being hungry!). Repeated mental rehearsal may therefore serve to ready potential prey for rapid, and hopefully life-saving response. Applying this logic, the repetitive memories experienced by a victim in the first few days or weeks after a trauma could serve to prepare for escape or response to a second trauma. One of the hallmarks of PTSD is that the repetition process does not stop, and in fact may persist for years in the form of dreams and intrusive memories. What was probably a useful rehearsal mechanism has persisted even though the immediate danger has past.

Dr. Andrew P. Levin

Like rehearsal to deal with a future trauma, the ability to identify cues that signal possible danger, such as a similar location, should have a protective effect. If lions stalked prey near the waterhole, that place should trigger an alerting response for the prey. Soon after a trauma victims become fearful of reminders of the incident and avoid situations similar to the traumatic event. As with intrusive memories and flashbacks, the person who develops PTSD continues to fear and avoid reminders of the event long after the trauma. As a PTSD sufferer moves into recovery the scene of the trauma evokes less fear and avoidance, although some fear may persist for a long period of time.

The final characteristic set of responses seen in PTSD is usually referred to as "hyperarousal:" restless, interrupted sleep, jumpiness, and excessive startling. All of these patterns are consistent with a state of alert. If danger is near, or may return, a sound sleep could be catastrophic. Instead, the animal in the wild needs to be ready to respond. Most trauma victims report a brief period of restless sleep and jumpiness lasting a few days or weeks after the trauma, whereas those who develop PTSD do not appear to turn off this response. Treatment of sleep disturbance in people suffering from PTSD is a major issue requiring careful use of medications as well as relaxation, exercise, and proper sleep habits.

With this framework for understanding PTSD, the patient and therapist can collaboratively understand the symptoms as normal responses to life-threatening danger which persist beyond the time when they are useful. The challenge now in the PTSD field is to understand what factors cause the normal responses to become exaggerated and persistent. Armed with this knowledge we maybe able to prevent the development of PTSD by specific interventions immediately following the trauma.

Treatment Center for Trauma and Abuse at WJCS

By Sylvana Trabout, CSW
Assistant Director

The *Treatment Center for Trauma and Abuse* (TCTA) is a program of *Westchester Jewish Community Services* (WJCS) that works with child and adult victims of sexual abuse and domestic violence as well as sexually aggressive and offending youth and adults. Its purpose is to heal the long-term pain and trauma of abuse in families. After working with victims of incest for more than 15 years and domestic violence victims for more than 5 years, the TCTA was established in October 2000, in order to formalize a working model of several trauma focused programs within WJCS. They are: the Child Sexual Abuse Treatment Program, the Partner Abuse Intervention Program, the Long Term Counseling Program for Adult Survivors of Sexual Abuse, *Safety Net* and *A Step Forward*, and the Juvenile Sexual Offender Treatment Program.

VICTIMS: Three of the programs within the Treatment Center for Trauma and Abuse provide a targeted focus on specific family members who are victims of abuse. The *Child Sexual Abuse Treatment Program* serves children 18 years of age and under who were sexually abused. In most cases, a family member or friend who had a prior relationship with the child perpetrated the abuse. As on of the oldest of taboos, child sexual abuse and incest affects 1 in 4 girls and 1 in 9 boys before the age of 18. It cuts across age, socio-economic, ethnic and racial groups. An integral part of the program is its team approach to working with victims, offenders and non-offending parents to heal the trauma and impact of incest on the entire family. The *Partner Abuse Intervention Program* works to heal the long-term impact of domestic abuse on adult and child victims. These individuals frequently are identified within the WJCS clinics when they present for symptoms of depression, post traumatic stress disorder and anxiety. Domestic violence is most frequently perpetrated against women by their intimate male partners and occurs in families regardless of status, culture, race or religion. The *Long Term Counseling Program for Adult Survivors of Sexual Abuse* is funded by the New York State Crime Victims Board (CVB) to provide therapy for adults who were sexually victimized as children. Women and men who were sexually abused as children receive therapy regardless of ability to pay. Contact Sylvana Trabout, Asst. Director, Treatment Center for Trauma and Abuse at (914) 949-7699, ext. 371 for further information or an intake appointment.

AT RISK YOUTH: Increasingly the mental health profession is identifying young people who display sexual behavior that is inappropriate and requires early intervention. *Safety Net* and *A Step Forward* are programs that seeks to reduce the incidents of sexual abuse by juveniles in Westchester County by providing intensive early intervention to at-risk youth and their families. It is a team approach program that provides early intervention and includes individual and group therapy, family and community intervention services, life management skills and wrap-around services such as transportation and recreation. *Safety Net* is a community-based program for seriously emotionally disturbed youth who display sexually inappropriate behavior and is funded through the Westchester County by the SAMHSA grant. *A Step Forward* was developed in partnership with the Westchester County Department of Probation provides early intervention with at risk youth ages 7-15 who have a PINS and are at risk for problematic sexual behavior. Both programs require the families to participate fully and cooperate with the program objectives. *Contact Consuelo Guerrero, CSW at (914) 423-4433, ext. 22 for further information.*

JUVENILE SEXUAL OFFENDERS: The *Juvenile Sexual Offender Treatment Program* (JSOTP) provides risk assessment evaluations to assist the Family Court in disposition planning for adjudicated sexual offenders. Under the Westchester County Department of Probation *JSOTP* also offers intensive community-based services for youth who have committed sexual crimes who are mandated into treatment. *All referrals for JSOTP* are *via the Westchester County Department of Probation.*

ADULT INCEST OFFENDERS: Working with the entire family is an important part of the *Child Sexual Abuse Treatment Program*. That includes providing counseling for adult incest offenders and working closely with the entire family to establish safety for the child victim. When appropriate, the *Treatment Center for Trauma and Abuse* staff works with the family and the Westchester County Department of Probation to provide safety planning for family reunification.

The services offered by the *Treatment Center for Trauma and Abuse* address the needs of families who are traumatized by sexual and domestic abuse. It provides therapeutic interventions and prevention programs using skilled staff and an integrated team that works collaboratively with law enforcement and county service providers.

Maniscalco Lecture At Saint Joseph's Medical Center Focuses On Finding Creative Solutions To Homelessness And Mental Illness

Staff Writer
Mental Health News

Mr. James A. Krauskopf, M.P.A., presented the Twelfth Annual Anthony Maniscalco, M.D. Lecture in Public Psychiatry to the Department of Psychiatry of Saint Joseph's Medical Center in Yonkers, N.Y. on June 21, 2001. The lecture was created in honor of Dr. Maniscalco who had been the Director of the Department of Psychiatry from 1970 until 1980, a period during which a number of the full range of mental health services currently available at Saint Joseph's were established.

Dr. Barry B. Perlman, Director of the Department of Psychiatry, introduced this year's lecturer. Mr. Krauskopf, has a broad background in the field of public policy based on years of experience in the public and private sectors. Currently a Senior Fellow at the Aspen Institute, he had served as Commissioner of the Human Resources Administration of the City of New York during the administration of Mayor Ed Koch and then as Dean of the Robert J. Milano Graduate School of Management and Urban Policy at the New School University. More recently he served as President of the Corporation for Supportive Housing and it was to this subject that his presentation, entitled " Housing the Mentally Ill: getting from good models to social policy", was addressed.

Mr. Krauskopf noted that homelessness and mental illness have been intertwined and persistent problems in New York City for more than two decades. Over this period public policies and service models for the people affected have evolved positively – away from the large public shelters of the 1980's, which were created in response to political and legal necessity, to the many varieties of more effective supportive housing in operation today. We now have successful models for housing and treating mentally ill, experienced community based provider organizations to establish and manage them, and State and City government programs to finance the essential mix of housing development capital, operating subsidy, and and services funding. He then asked, " So why does the plight of the homeless mentally ill continue as such a serious problem in New York, sometimes attracting media attention and sometimes not?"

The joint State/City, New York/ New York program, which began in 1990, led to the development of more than 3,600 units of housing eventually serving approximately 7800 people. It was followed recently by a more modest renewal that will create 1,500 more housing units when development is completed.

Mr. Michael Spicer, President & CEO, Saint Joseph's Medical Center, James Krauskopf, M.P.A., this year's Maniscalco lecturer, Barry B. Perlman, M.D., Director, Dept. of Psychiatry, St. Joseph's Medical Center, Steven J. Friedman, Commissioner, Westchester County Department of Community Mental Health

A research study completed this spring by the University of Pennsylvania has documented substantial public cost savings for homeless people who went from public shelters into supportive housing. Government funds saved for each person are nearly as much as what it costs to build, operate, and provide supportive housing and services, compared with the costs of the inchoate pattern of mentally ill people moving in and out of public institutions, streets, parks, transit stations, City shelters, and elsewhere.

In other words, Mr. Krauskopf asserted, "If we had public policies that could transfer the money to be saved by City homeless shelters, state psychiatric centers, municipal, veteran's, and voluntary hospitals, jails and prisons, we could create sufficient financing for ongoing development of permanent housing and services. In a few years, that kind of intelligent public policy could bring an end to this harmful and embarrassing phenomenon of people who are mentally ill and homeless that we have unnecessarily come to accept as part of our urban society." While the address focused on the issue as it has come to exist in New York City, the same analysis applies to the problem as it exists in the inner city, urban areas of Westchester County.

***Right Directions* from page 7**

of release, and

- Access to treatment and community support services immediately upon release.

As critical as it is to reach and engage people with high needs and high risk, it is also important not to neglect people with mental illnesses who are cooperative and comparatively easy to serve.

The problem of long waiting lists for treatment continues, and we are beginning to hear reports that because the "high-needs high-risk" population gets first priority for case management, housing, and treatment services, quieter people with serious mental illnesses are not getting services they need. This is a matter of concern.

Housing, community support, and high quality, individualized treatment services are important to all people with serious mental illnesses.

We want to stress especially the importance of safe, decent, stable housing. Too many people with serious mental illnesses still live on the streets or in shelters. Too many people live in squalid or dangerous settings. Too many people live with families who will not be able to take care of them forever. Too many people lose their housing when they have a psychiatric crisis. It is easy enough to imagine how unhinging it is to lose your home and your possessions. Imagine how totally disorienting it is to have to move from place to place every time your illness re-occurs. Decent, stable housing is central to good community mental health.

We also need to acknowledge that many people who are currently served by the mental health system, and whose psychiatric conditions are relatively stable, find their quality of life in the community unsatisfactory. The goal of community mental health is not merely for people to live in the community. The goal is for people with mental illnesses to be full-fledged members of the community. For the most part this has not happened, and the greatest disappointment for most people with mental illness in the community is that they don't have jobs. For many people with psychiatric disabilities, work is critical to their sense of self-worth, just as it is for people who are not disabled.

The mental health system needs to focus far more attention on work, including expansion of rehabilitation and job support services and the elimination of disincentives to work through, for example, the passage of The Medicaid Buy-In Bill.

Obviously, there is much more we could add about underserved populations, but because we are constrained by time, we will just make six, quick final observations.

1. Both expanding community-based services and improving quality depend on being able to recruit and retain competent staff. One major obstacle is low pay. OMH's budget proposal for this year begins to address this problem, but more will be needed.

2. On p. 4, the plan says, "The goal for the 21st century is a shift from community-based systems of care that treat recipients to community-integrated systems that serve customers who desire to design and manage their own recovery and move on with their lives." We certainly agree that recipients should be treated like valued customers and that mental health services should be oriented to recovery and independence. But we are concerned that the statement seems to de-emphasize the importance of treatment. We need a mix of rehabilitation, peer support, family support, housing, and treatment to help people lead decent lives in the community. Treatment is a critical part of the mix and is not incompatible with good customer service. In addition recent advances in treatment technology and in evidence-based models make the use of treatment more hopeful than at any other time in history.

3. Although we strongly support improved accountability and coordination, we worry about how to avoid creating administrative nightmares in which the complexity of process overwhelms the goal of service.

4. The plan notes the state's support of using recipients as paid mental health workers, but only in passing. We believe that the development of a virtual profession of peer providers has been one of the great contributions over the past decade. Peer providers have great value in the effort to reach and engage people who reject traditional mental health services. They also have great value as role models. And, because they are good at their work, they are great anti-stigma agents.

5. We were very disappointed that the plan merely notes the problem of stigma and does not stress the great importance of overcoming it so that people with mental illnesses can live as members of the community rather than being merely tolerated. Overcoming stigma is central to achieving the goals of community mental health. But, to do so, we believe, it is critical to change the paradigm regarding overcoming stigma from a focus on change of attitude to a focus on change of societal behavior regarding access to community resources such as housing, work, education, and social and recreational opportunities. Stigma is discrimination, and it should not be tolerated as something that will only change slowly over a great deal of time.

6. Finally, we are disappointed that the plan does not provide estimates of need. We believe that it is very important to have a relatively clear sense of how many people are underserved, how many more units of housing are needed, how many more case managers, etc. With these kinds of numbers, it would be possible to cast a multi-year plan that commits to specific amounts of development in each of the next five years--which we believe is the essence of what a five-year plan should be.

***New Freedoms* from page 7**

2001 Paul G. Hearne/AAPD Leadership Awards applications is July 26, 2001. To download the application, go to www.aapd-dc.org or to request a print copy, call 800 840-8844 and speak with Jessa Steinbeck.

4. Bipartisan Support for Disability Rights in Garrett Amicus Briefs. When the Supreme Court agreed to hear the University of Alabama's challenge to the constitutionality of the ADA as applied to state employers, the disability rights community rallied around the disabled employees Patricia Garrett and Milton Ash. Former President George H. W. Bush joined with Senators Bob Dole, Orrin Hatch, John McCain, Jim Jeffords, Tom Harkin and Ted Kennedy in filing an historic amicus brief in support of the ADA's constitutionality. Equally important, a bipartisan group of 14 state attorneys general, led by the attorney general of Minnesota, weighed in on the side of the ADA. Although we lost the case in a 5-4 decision, it is important to recognize that when ADA was challenged in our highest court, the law's bipartisan champions were there to defend it in force.

5. March for Justice and ADA Watch. On October 3, 2000, more than 4,000 people with disabilities and disability rights advocates attended a rally and march to the Supreme Court in Washington, D.C. to call attention to the challenges to the ADA and the importance of the Presidential elections for the future of the Supreme Court. Speakers included civil rights luminaries like Martin Luther King III, Jesse Jackson, and Dick Gregory. The "March for Justice" attracted the support of a broad coalition of disability organizations from AAPD to the National Council on Independent Living (NCIL) to ADAPT to the National Association of Protection and Advocacy Systems (NAPAS) to the Consortium for Citizens with Disabilities and on and on. Many of the same groups have been working together since January of 2001 as "ADA Watch." This coalition, which includes new groups like the National Disabled Students Union (NDSU), is working to protect, defend and restore the ADA. Kudos everyone who participated in the March for Justice and kudos to Jim Ward at NAPAS for coordinating ADA Watch!

6. National Disabled Students Union. In response to the Supreme Court's unjust decision in Garrett v. University of Alabama, disabled students Sarah Triano from the University of Illinois at Chicago and Daniel Davis from U.C. Berkeley formed a new organization called the National Disabled Students Union. Their coalition has attracted participation from hundreds of students with disabilities around the country, many of whom participated in a "National Leave Out" on April 17 designed to raise awareness of the implications of the Garrett decision and the resurgence of states' rights. Go Sarah! Go Daniel! Go NDSU!

7. Olmstead Executive Order. In June, President George W. Bush signed an executive order designed to speed up the process of implementing the Supreme Court's decision in L.C. v. Olmstead requiring States to end unnecessary institutionalization of people with disabilities under State Medicaid programs. The Order contains strong language that calls for aggressive leadership from the Federal government to protect the rights of individuals who continue to be stuck in institutions because they need long-term services and supports and their state has given them no home and community-based alternative. Kudos to President Bush and kudos to ADAPT, NCIL, and others who kept the pressure on the President to deliver on his campaign promise to issue such an order!

8. PGA Tour v. Martin. Seven Justices of the U.S. Supreme Court, led by Justice Stevens (a golfer), issued a decision this term requiring the PGA Tour to accommodate disabled golfer Casey Martin by allowing him to ride in a golf cart between shots. This decision is an important victory for the individualized analysis of what is "reasonable" under the ADA. Go Casey! Go Justice Stevens!

9. Congressman James Langevin. In November, 2000, Rhode Island residents elected James Langevin to represent them in Congress. A wheelchair-user, Congressman Langevin is paving the way for others with disabilities to join him in the U.S. House of Representatives. I look forward to the day when the Congressional Disability Caucus has the size and influence of the Congressional Black Caucus. Go Congressman Langevin! Go Rhode Island!

10. National Council on Disability's Unequal Protection Under Law Reports. The National Council on Disability (NCD), an independent federal agency with nine staff and 15 council members appointed by the President and confirmed by the Senate, has issued a number of hard-hitting reports under the series entitled "Unequal Protection Under Law." These historic and courageous reports document years of inadequate enforcement of federal disability rights laws like ADA, IDEA, and the Air Carrier Access Act. Visit www.ncd.gov to get a copy of the reports. Kudos to NCD for speaking truth to power!

11. Kyle Glozier's Speech at the Democratic Convention in 2000. Kyle Glozier, a 14 year old with cerebral palsy from Pennsylvania who wants to be President when he is old enough, delivered a powerful speech on behalf of the disability rights community at the Democratic Convention in Los Angeles. His speech was not aired in prime time, and unfortunately disability rights issues received very little prime time coverage at either convention. However, Kyle once again demonstrated the power of a single voice in the fight for justice. Go Kyle!

Mental Health News WebLink Note:
Visit AAPD's Website

www.aapd.com

PTSD Treatment - An Overview

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The modern treatment of Post-Traumatic Stress Disorder (PTSD) may involve a combination of psychotherapeutic and psychopharmacological therapies. The goals of treatment would include that the person is no longer consumed by distress from the trauma, able to contain such distress or even free of distress. The psychotherapeutic approaches to PTSD may be undertaken in either group or individual sessions. A variety of psychopharmacological agents have been used with some success in the treatment of this condition, although only one medication has received Food and Drug Administration approval for labeling as a treatment.

Psychotherapeutic treatments for PTSD involve dealing with the trauma, the effects of the trauma on one's sense of oneself and the effects of the trauma on facing other situations in life. These psychotherapeutic treatments are themselves constituted of components of other types of treatment. Most psychotherapies for PTSD include educational components. To the educational component is added explorations of thoughts and feelings. In some treatments, the exploration of the thoughts follows a path that is easily traced from session to session. Other treatments let the thoughts wander, looking for threads that weave a coherent picture together. Feelings are explored either in the context of the thoughts that preceded them or in their own right. Different therapeutic approaches will emphasize different components at different times in the treatment process.

Incorporated into the definition of PTSD is the exposure to an extreme, frightening situation. At some point in the psychotherapy, detailed review of the traumatic situation is often undertaken. Needless to say, the review of the traumatic event often calls up very strong and uncomfortable feelings. Thus the review must be timed and paced in such a fashion that the individual is able to think about the situation as well as re-tell the story. For individuals who have never before undergone a re-telling of the story—often because of feelings of shame, guilt and anger—such a re-telling may have substantial beneficial effects. In the process of re-telling the trauma, there is exploration of the immediate response at the time, how to understand that response, as well as how one thinks about the actions today. Oftentimes, individual's shame and guilt stem from beliefs about how they *ought* to have acted at the time. These beliefs require exploration since they often are clouded by either information not available to them at the time or expectations of themselves that were not realistic at the time of the event.

Traumatic events that occurred during the formative years of childhood may be particularly problematic. A child has a limited ability to process information and experiences. However, the adult looking back on the experience may have great difficulty accepting that the traumatic event occurred to them. Sometimes people are unforgiving of themselves as if they should have had the knowledge, willfulness or strength to do things that in fact they did not possess as children. Early childhood experiences may not be easily discussible in that they were never understood in ways that are readily accessible to discussion. Sometimes the treatment rests on accepting oneself, rather than re-working the traumatic experience, and pharmacological means to manage the damaging emotional effects of the trauma.

Traumatic events are often experienced as a commentary on one's self-worth. Rather than seeing the trauma as bad luck or being in the wrong place at the wrong time, the person feels responsible for something that they were not in fact responsible for. Hence there evolves a sense of guilt and shame over the occurrence of the trauma. When the person, him- or herself, realizes that there is no reason to be involved in self-blame, they then may feel like they are going crazy, because they understand that the way they feel makes no sense. Such feelings often inhibit a person from seeking help.

Psychopharmacological treatment of PTSD is driven by the predominant symptom pattern. The only FDA labeled medication is from the class of selective serotonin reuptake inhibitors (SSRIs), the class that includes citalopram, fluoxetine, fluvoxamine, paroxetine and sertraline. It has been assumed by most clinicians that any of these medications is likely to work. When PTSD is associated with much depression or anxiety, one of the SSRIs is likely to be chosen as the sole treatment. If there is long standing and significant anxiety, buspirone, an anti-anxiety medication may be added to relieve the anxiety and boost the effectiveness of the SSRI.

For situations in which the person is suffused with anger and has associated mood instability, treatment with a mood-stabilizing agent such as lithium carbonate or divalproex is not uncommon. Alternatively, medications that are currently labeled by the FDA for treatment of seizure disorders are often used as mood-stabilizers. These medications include carbamazepine, gabapentin, lamotrigine and topiramate. While the use of such medications is becoming commonplace, the FDA has not labeled them for such psychiatric uses. Particularly when a patient has intrusive images that persist despite treatment with an SSRI, an anticonvulsant may be added.

Medications that are considered antipsychotic agents—including haloperidol, risperidone, olanzepine, quetiapine, ziprasidone—are sometimes used to treat PTSD. Individuals who suffer from recurrent flashbacks, and act impulsively and violently as if they were in the traumatic situation, are sometimes treated with antipsychotics. Antipsychotic medications may also be used to supercharge the effects of antidepressants.

Safe At Last...Or Is She?

By Mindy Appel, LCSW, ACSW, DAPA, BAS

This is Nicole's story—a courageous 18-year old Louisiana State University student, whose life drastically changed on Monday morning, July 24, 2000, as she parked her car in the customary place in front of the mall and anticipated a day of work at Williams Sonoma.

This is also about the incredible courage of her parents, older sister, and an out-pouring of care and concern from her family and friends, from the Sheriff's department, and from the community at large. Nicole's traumatic sojourn galvanized everyone into a united support system facing the intensity of panic and anxiety, fear, shock, sadness, and anger that such a thing could happen in a populated area, in broad daylight, in the year 2000.

It began innocently enough as Nicole pulled into Lakeside Shopping Center, in Metairie, and parked her car in the usual place. She was sitting in the car, gathering her purse and about ready to go into the mall to report for work, when a man approached the driver's side of her car out of nowhere, and thrusting a loaded .22-caliber pistol in her face, he ordered her to move over to the passenger side of her car, and he got in and started driving east on Interstate 10. From the Times-Picayune newspaper article concerning the abduction, the following description was offered: "This was the man police would later identify as Paul Will. He had thick red hair, a scruffy beard and a scar on his face. He wore floral shorts and black tennis shoes, and he looked like he hadn't showered. The words "Broken Mold" were tattooed at the base of his neck."

As the car accelerated through the I-10/610 split, Nicole had no idea where she was going or what was going to happen to her. She didn't know whether this man was going to rape her, kill her, or both. All she knew was that he was armed and dangerous and that she had little choice in the situation but to remain where she was and cause as little trouble as possible.

During the next 18 hours, Nicole and her abductor covered 1,200 miles, driving from New Orleans to Philadelphia, Pennsylvania, stopping for food and gas along the way. Each time they stopped, the man used Nicole's Visa debit card to make his purchases.

Mindy Appel

Nicole remembers that this man drove both safely at times, and like a maniac at other times, which matched his moods as well. He went from a kind, concerned fellow traveler, wondering if she were cool enough, and comfortable, to a gun-waving tyrant, intent on getting back at her for the sadness he felt inside. Nicole described him as depressed, and often talking of committing suicide while they were driving, and complaining about how miserable he felt and how bad life was. Nicole's only thought was to keep him talking and driving, and keep his thoughts away from the gun he always held in his hand.

From the very start, Nicole was assured that she would not be hurt. What she could not have known was that this strangely sad man had taken a Greyhound bus from Philadelphia to New Orleans just three days before in hopes of reconciling with his ex-girlfriend, a Tulane University medical student. When she threw him out of her house, he became very upset and decided he would go back to Philadelphia, and perhaps buy enough heroin to overdose, authorities reported. He had spent the night sleeping outside beside a muffler shop, and claims to have been robbed of $60,000 and beat up while asleep. Authorities could find no proof that this actually happened. That morning, he showed up outside of Lakeside Mall, where his ex-girlfriend also worked at another business, and when Nicole drove in, he saw his opportunity.

During this incredibly long, arduous "drive to nowhere", Nicole tried desperately to keep this man talking about anything and everything. She remembered that people in these situations often kill their captives because they don't think of them as "persons", but as property, so she tried hard to appeal to him on a personal level, telling him about how her grandfather had died of cancer three years before, and encouraging him to think how sad his mother would be if anything happened to him. Between conversations, Nicole cried quietly behind her sunglasses, so he could not see her, and thought about her family and friends, and wondered if she would ever seem them again.

When night fell, it got very cold in the car, and also very quiet. But always, Nicole could feel the presence of this man with a gun, and she knew she had to keep her wits about her. She prayed constantly, she said, not for being rescued, but more for the wisdom and courage to know what to do if something happened.

By the time they got to Philadelphia, she was sure this gun-wielding man in the seat next to her was not going to hurt her and she relaxed just a little. At approximately 1:20 a.m. on Tuesday morning, in an upscale section of downtown Philadelphia, he pulled the car over, handed her a sweatshirt, told her to stay warm and call her parents, and drove away. With the help of two men who happened to be on the street at that hour of the morning, Nicole flagged down a police car, and a short time later, police located her car with Paul Will still inside. He was arrested and put in jail in Philadelphia under a $5 million bond. He was charged in two states with 17 separate crimes, ranging from kidnapping and carjacking to armed robbery. At the time, he was also due to fact federal charges because the alleged crimes crossed state lines.

Nicole returned to New Orleans on Tuesday night to a hero's welcome and an endless stream of family, friends, and well-wishers who stopped by her house after greeting her emotionally at the airport.

Understanding normal responses to abnormal events can help people cope effectively with feelings, thoughts, and behaviors along the path to recovery. The purpose of this article is to explain Nicole's "true survivor" ordeal and to help people understand acute catastrophic stress reactions which fall under the diagnostic category of Post-traumatic stress disorder, which is described in the DSM-IV (Diagnostic and Statistical Manual) as: "..a natural emotional reaction to a deeply shocking and disturbing experience. It is a normal reaction to an *abnormal* situation."

In cases of PTSD, the person experiences a traumatic event in which they are confronted with actual or threatened death or serious injury, and their response to this situation involves intense fear, helplessness and horror. Following the event, they persistently re-experience recollections of the event, sometimes in the form of dreams, or sometimes in the form of the event actually recurring. People with PTSD generally experience intense psychological distress when confronted with things that remind them of the event as well. In an effort to get rid of these uncomfortable feelings, they avoid thoughts, feelings, and conversations associated with the trauma, and/or they avoid activities, place and people that make them remember the trauma.

Sometimes, they are unable to remember parts of what happened. In many cases, the person afflicted with PTSD has decreased interest in activities in which they used to be deeply involved, and they sometimes feel estranged or detached from others (Nicole used the term: "numb.") In addition, they are often not able to give and receive loving feelings, and they sometimes begin to believe that they will not have a normal life, and that life will end abruptly.

People with PTSD sometimes show symptoms that were not present before the trauma occurred such as: difficulty in falling and staying asleep, irritability and outbursts of anger, difficulty concentrating, hypervigilance, and exaggerated startle response. They often feel fragile and hypersensitive to comments they would have ignored before. On occasion, they will have physical manifestations of the stress such as joint and muscle pains. In addition, many suffer from panic attacks, fatigue, low self-esteem, exaggerated feelings of guilt, and feelings of nervousness and anxiety.

Many people who experience traumatic events show no visible outward signs of injury, but there is a serious emotional reaction to such experiences. Research has demonstrated the effectiveness of cognitive behavioral therapy and group therapy, as well as medications which assist in relieving

see *Safe At Last* on page 31

***Safe At Last* from page 30**

the symptoms of depression and anxiety and ease sleeplessness.

As with every human event, no two people respond in exactly the same way to extreme stress. Some people have immediate reactions, while others may not respond until months or even years after the trauma. Likewise, some people recover quickly, while others experience adverse effects over long periods of time. In some cases, the people who seem to bounce back the fastest are also the ones who later become discouraged and depressed.

Although it is impossible to predict the length of time any one person will need to recover from a traumatic event, there are three significant factors which contribute to this variable: the duration of the event – and the seriousness of the loss; the person's intrinsic ability to handle emotionally exhausting situations; and other life events preceding the trauma which were stressful.

The American Psychological Association publishes a website called "Practice Directorate" which talks about steps to healing which they recommend: (www.apa.org/practice/traumaticstress)

Be patient with yourself. Healing takes time. Ask for help from your personal "support system"; communicate in the way you feel most comfortable; if you don't want to talk to people, write in a diary. Join a support group for others who have had similar experiences. Eat well and get enough rest and exercise; avoid alcohol and drugs. Keep to routines—eat at regular times, exercise at regular times, sleep at regular times, and pursue hobbies you enjoy, but have not made time for recently. Avoid major life decisions while you are recovering (changing jobs, etc.). Learn about post-traumatic stress and how it affects people.

Permission to write this article was granted by Nicole and her family so that more people may become aware of the dangers associated with recovering from traumatic experiences. I have had the honor of working with this family throughout this most difficult journey. Fortunately, the outcome here to the kidnap and flight is very positive. It might not have been.

The family, despite feeling chronically fatigued and exhausted, is trying to get back to a "new normal," as life will never be quite the same. They are starting to attend church regularly again, and they are trying to be more aware of each other and how important it is to savor life's simple moments more often. Nicole's mother and father and her sister have gone back to work, and she has gone back to Louisiana State University to start her sophomore year. But nothing will ever be the same.

Postscript: Nicole's story was covered on a segment of "Dateline" on national television this Spring. As this goes to press, Paul Will is scheduled to come to trial on June 18, 2001. It has been rumored that he will plead "Not Guilty" and, if successful, he will be released to resume his life as a free man. This is certainly an ironic commentary on the judicial system – that the perpetrator may "resume his life as a free man" while the victim, whose only crime was being in the wrong place at the wrong time, will forever be changed by this event.

Mindy Appel, LCSW, ACSW, DAPA, BAS, is a practicing private psychotherapist in Metairie, Louisiana, a suburb of New Orleans. She has been in private practice for almost 20 years. Mindy graduated from Ithaca College in 1978, and completed her Master's Degree in Social Work at the Tulane University Graduate School of Social Work in 1979. She has been recognized as a Diplomate and is licensed and board certified as a psychotherapist.

PTSD and Domestic Violence

By Lisi Lord, M.A. and
Julie A. Domonkos, Esq.

"What, she's not neurotic! When her son is ill, she develops all the symptoms of insomnia."

Marcel Proust

The domestic violence movement and psychotherapeutic practice have historically often been at cross purposes when working with survivors of domestic violence. Since the 1970s, feminists in the domestic violence movement have emphasized that the situation of the individual battered woman must be understood in the societal and political context in which it occurs. As the prevalence and severity of domestic violence came into our social consciousness through decades of grass roots activism, battering of women by men came to be understood as a direct outgrowth of patriarchal social structure. Battered women's advocates refuted the generalized notion that women were battered because of their individual pathologies. Activists experienced first-hand the barriers that battered women faced when they tried to get free of their abusers, including lack of shelter, economic dependence, inadequate police response, and gender bias in the courts. Activists shifted the focus of blame away from the battered woman and onto her abuser, who abuses because it gets him what he wants from his victim/partner and because society historically, and still today, fails to hold him accountable for his use of violence. Research supports the position of the domestic violence movement: despite numerous studies, no research has been able to show persuasively that any one woman is at greater risk of becoming a victim of domestic violence than any others. Being female is the single reliable risk factor.

This socio-political vision has been at odds with traditional models of psychotherapy, which have sought to locate a core of the problem in the victim herself. Traditional psychoanalytic thinking might view her as being a masochist who pursues relationships in which she will be dominated and controlled. Other theories would look to blame her low self-esteem or history of child abuse for a significant part of the problem. More recently, battered women have been labeled co-dependent, meaning that they have some need to be in a relationship with a partner who has an addiction, in this case an addiction to power. All of these approaches offer a promise and a trap. The promise is that, if she can somehow overcome her internal pathology, then she will gain the tools necessary to leave the abuser. The trap, of course, is the assumption that since she chose to be in the abusive relationship to begin with, she can freely and safely choose to leave it. Domestic violence advocates have long known, from anecdotal experience working with victims and from the research, that the time when a victim is most at risk of harm is when she tries to leave her abuser.

Thus, advocates posit that any model viewing battered women solely from a clinical perspective is problematic. First, it erroneously implies that women have chosen the abuse and can therefore "unchoose" it. Second, it minimizes the danger that battered women (and their children) face if they attempt to escape from the abuser. Finally, it contributes to victim-blaming, which has historically been our culture's way of avoiding confrontation with the sole source of the violence: the abuser. Such an approach ignores the fact that abusers use violence to strip away the power of their victims, and that abusers are solely responsible for *their* choice to maintain power and control over their partners in this way.

In 1980, the American Psychiatric Association added the diagnosis Post Traumatic Stress Disorder to the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM III). This diagnosis promised a huge step forward for all individuals who had been impacted by traumatic events. In particular, PTSD gave survivors of past or present abuse a diagnosis that explained their symptoms in terms of an external event and not some internal deficit. In the quote we open with, Proust's point in poking fun at the doctor is that the doctor's wife is hardly a neurotic suffering from insomnia but rather a concerned mother who stays awake at night when her child is ill (even more understandable at a time before Tylenol and antibiotics existed). Similarly, the introduction of the PTSD diagnosis made clear that battered women often exhibit symptoms not because they are mentally ill per se but because they are suffering the typical after-effects of trauma, which occurred because of violence by the abuser. PTSD defined a list of symptoms that were said to be the result of a traumatic event outside of what could normally be anticipated in a person's life, such as war, rape, childhood sexual abuse or domestic violence. The thinking was that these were traumas that people generally do not have the internal resources to cope with.

Domestic violence advocates hailed PTSD as a diagnosis that did not blame the victim for her symptoms. It gave credibility to what advocates had long known from their work with victims: that battered women who develop symptoms such as depression, anxiety, low self esteem, disassociation, numbing, eating disorders, substance abuse and flashbacks often do so as a result of being battered and not because of their fundamental personality structure. Over time, however, the PTSD diagnosis has not proven to be as helpful as had been hoped. The reasons for this are complicated, but first and foremost, a PTSD diagnosis still has the effect of ignoring the broader social/political context of abuse. The victim's reactions, symptoms and behaviors are still viewed in isolation. This can lead to her behaviors being explained in terms of her diagnosis and not as a realistic assessment of her actual danger.

Here is an example. Mary, who was battered by her husband for many years, has a strong panic response to the smell of pipe tobacco. If she is out walking and encounters this smell, she becomes anxious, disoriented and weepy. A therapist who views Mary as suffering from PTSD might explain this behavior as an experience of Mary being "triggered." What the therapist might miss is that Mary's husband, a pipe smoker, has been stalking her and Mary realistically fears that the pipe smoke indicates that he is nearby. In this instance, the therapist, while understanding that the origin of Mary's behavior lies in the abuse she received at the hands of her battering husband, is still shifting the focus away from what her husband is doing to her. The treatment might then center on trying to help Mary desensitize to the smell of pipe smoke rather than on helping her access police and court assistance to stop the stalking.

It might be easy to dismiss the therapist in the above example as incompetent. Unfortunately, we need to consider why similar mistakes happen frequently in the therapeutic process. One reason is that the therapist only has Mary to work with. Mary's husband is out of the therapist's control. A related and more insidious reason is that the therapist may share the assumption, which Mary likely holds and which society in general has traditionally held, that the husband's behavior is a given. He is going to do whatever he does and Mary (and by extension the therapist) has to work around that. The therapist may be combating his or her own sense of powerlessness over the situation by focusing on helping Mary change rather than confronting the batterer and indeed the entire system that is facilitating the abuser's violent conduct.

In this example, Mary's reaction to the smell of pipe smoke is a rational response to danger because her husband is stalking her. The therapist's approach in trying to change her reaction is not only likely to fail since it is based on a false premise but also might endanger her by persuading her that her panic is not based on a real risk.

The implications for battered women go beyond ineffective therapeutic intervention, although that alone warrants a better understanding and approach when dealing with PTSD in domestic violence cases. Domestic violence victims frequently go to court to get orders of protection and custody of their children. For many victims, such court orders are absolutely necessary if they are to break free of the abuser. When an abuser has unfettered access to his children who are in the care of their mother, nothing will stop him from continuing the abuse. When litigating child custody, the parties are usually required to undergo a forensic evaluation. Mental health professionals meet with the parties and make assessments that guide the judge in the custody determination. In New York State, since 1996, judges in all cases involving the custody or visitation of children are mandated to consider evidence of domestic violence. This law came about because of the evolution of research showing clearly that children of men who abuse their partners suffer harm, even when the children are not directly abused themselves. However, nothing comparable to this law for judges covers forensic evaluators. Traditionally domestic violence was missed, ignored, minimized or blamed on the victim in forensic reports, resulting in injustice to the victims, empowerment of the abusers, and harm to the children who were awarded into the care of violent fathers.

Many forensic recommendations in custody cases are based on the affect and conduct of the parent during the interview. Battered mothers exhibiting the symptoms of PTSD may, for example, appear over-anxious, scattered, angry and depressed. When these conclusions are written into the forensic report without a deeper analysis of the cause (i.e., the violence of the abuser) and the likely outcome (i.e., once the cause of the trauma is removed, the mother can function well again), mothers can and have lost custody of their children. In our work with domestic violence victims over the years, we have encountered many examples of battered women being inappropriately labeled depressed, unstable and even "hysterical" in forensic reports that at the same time make no mention of a lengthy history of domestic violence, or at best note the "assertions" that domestic violence had occurred and suggest that they are fabricated, exaggerated, or of little overall importance.

At the same time, we have seen mental health practitioners begin to address domestic violence appropriately and point the blame for the violence and its effects on the mental health of the victim squarely where it belongs: on the abuser. This trend towards a more in-depth understanding of PTSD in domestic violence cases will not only lead to better therapeutic interventions with victims and their children, but also fairer and healthier results in custody cases in court. We encourage all mental health practitioners to get formal training on domestic violence so that they can appropriately screen for it, assess it, and address it. We also encourage mental health professionals to partner with local domestic violence agencies so that concrete strategies for stopping the abuser and holding him accountable can be developed in a team approach that also facilitates the emotional healing of the victim.

Lisi Lord is Associate Director of Programs and Julie Domonkos is Executive Director of My Sisters' Place, a domestic violence services and advocacy agency serving Westchester County. For information or help, call 1-800-298-SAFE.

References Available on Request

PTSD Addressed At Family Services of Westchester Elder Abuse Prevention Domestic Violence Services

By Marjorie Leffler, CSW
Senior Program Director
Family Services of Westchester

Posttraumatic stress disorder (PTSD) can develop following personal exposure to dangerous or horrific events such as accidents or violence. Victims of PTSD may re-experience the event and suffer from a variety of acute or chronic symptoms as they struggle to integrate the extraordinary traumatic experience and go on with their everyday lives. With its seven clinic locations, Family Service of Westchester (FSW) has long helped victims of PTSD work through and overcome their trauma whether it be caused by an accident, domestic violence or crime victimization. FSW also provides Critical Incident Stress Management services, such as debriefings, in the initial period immediately following traumatic events, in order to prevent the later development of PTSD.

Another way FSW addresses one of the specific forms of domestic violence is through its elder abuse prevention services. As with other types of family violence, elder abuse crosses all geographic, socioeconomic, racial, ethnic and gender barriers. Elder abuse is so shocking that it is often hidden, denied or disclaimed by family members. Only in the last fifteen years have we as a society begun to recognize elder abuse as a serious problem. With the aging of the population, decreasing social supports and increasing cost of formal institutions, the number of substantiated elder abuse cases have increased more than 200% since 1987. It is estimated that over one million elder persons are abused each year in the United States. A 1996 survey documented that 32 per 100 persons over the age of 60 experienced verbal or physical abuse or neglect.

Elder abuse is an umbrella term that includes five recognized forms of behavior victimizing older persons: physical abuse, sexual abuse, emotional abuse, exploitation and neglect. It can be very difficult to detect elder abuse. Typically, abusive behavior occurs in private, and victims may be unwilling or unable to disclose such behavior due to fear of backlash from the abuser, fear of loss of contact with a family member, or fear of being placed in an institutional setting. Victims may feel shame and guilt about the mistreatment and thus are unwilling to report it. Furthermore, victims may be incapable of telling anyone, due to being socially or physically isolated and/or mentally impaired.

In light of the social and physical isolation that is so characteristic of elder abuse, an obvious barrier to providing services to victims of elder abuse is their inability to access traditional office-based clinics. In order to meet this need, FSW's geriatric outreach program offers home visits by clinical social workers and geriatric case managers who work closely as a team, bringing in other resources as needed to prevent and stop the abuse. This team approach enables a variety of services, including clinical mental health and supportive case management services, to meet the wide spectrum of needs experienced by a person experiencing or at risk of becoming a victim of elder abuse.

As the older population continues to grow, so, too, unfortunately, will the incidence of elder abuse. FSW therefore offers training in order to educate the community, social and medical service providers, employers, and individuals at risk of elder abuse about the nature of this terrible problem and how to prevent, detect and intervene when it is suspected.

For more information about elder abuse and services to prevent and treat it, call 948-8004.

The American Red Cross Disaster Mental Health Services

By Dorothy Brier, C.S.W.
Mary Tramontin, Psy.D.

Since 1881, the American Red Cross has been providing humanitarian, impartial and voluntary assistance to help people cope with disasters. Such events can be naturally caused (e.g., floods or hurricanes) or the result of human doing (e. g., transportation accidents or terrorist attacks). The most common responses by the Red Cross are to residential fires, which occasionally are the result of arson. The ultimate goal of Red Cross intervention is to enhance self-reliance and improve the quality of human life. Traditionally, the American Red Cross provides food, clothing, temporary housing, funeral expenses, and other essentials, as necessary. This assistance is fundamental in returning people to pre-disaster functioning. In 1990, a growing awareness of the emotional impact of disasters led to the development of an organized program for mental health service delivery. This article describes the American Red Cross Disaster Mental Health function as well as coping strategies to use during disasters.

Why Disaster Mental Health Services

Professional literature documents that traumatic events such as disasters elicit profound emotional reactions. Over ninety percent of these reactions are interpretable as normal reactions to abnormal situations. Disasters bring with them the sights and sounds of devastation and multiple losses. There are the losses, not only of life and health, but also of irreplaceable possessions, of beloved pets and of a sense of control over one's destiny. People who directly experience the disaster, their families and those who help are all affected. The latter vicariously experience trauma by hearing painful accounts and/or seeing the aftermath. Challenging work conditions and long hours add to the stress of service providers.

The goal of all Red Cross disaster intervention is to return people to pre-disaster functioning. Disaster Mental Health Services achieves this by alleviating disaster related emotional stress. Counseling is available so that recipients of the service can cope better by finding healthy emotional outlets and resolving upsets that can interfere with their use of other Red Cross services.

Red Cross Disaster Mental Health workers are volunteers with mental health licenses and advanced training from the organization. In New York, this volunteer is usually a Certified Social Worker, clinically trained doctoral level Psychologist, Mental Health Registered Nurse or Psychiatrist. The specialized training enables professionals to apply their expertise to the unique work done by Red Cross.

Mental Health volunteers work wherever clients (those directly impacted as well as their families and service providers) may be: at the disaster site, at the centers that are opened for large scale events, in clients' homes, at Red Cross offices or by telephone contact. They are on scene when there is suspected or confirmed loss of life or serious injury, when clients are observed to be experiencing severe emotional reactions, when there are vulnerable populations (such as the elderly, disabled or children) or when the disaster involves many people.

Disaster Mental Health is an integral part of comprehensive Red Cross services. Teamwork is crucial. Clients are self-referred, directed to services by American Red Cross workers and other personnel; or the mental health professional proffers services. The process of outreaching to the community and its members is an active one. Those on scene scan the disaster setting to identify signs of stress. Mental Health volunteers make themselves accessible by "walking and talking," and by positioning themselves in key locations. They wear discernible Red Cross identification. Depending on the circumstance, posted flyers announce a specific area and time when mental health professionals will be present. The non-verbal behavior of these volunteers, reflected in their visible, attentive and non-intrusive presence, conveys accessibility while providing ballast to a chaotic environment.

This informal, low-keyed approach makes it non-threatening for those affected to discuss their reactions, feelings and concerns. The Mental Health Services are short-term and the natural resilience of clients usually pre-empts the need for continued professional contact. However, referrals for on-going work are made when mental health needs exceed what can be addressed by brief clinical intervention.

Red Cross Disaster Mental Health services, given individually or in a group, are wellness-oriented and focused on strengths. The work is directive, geared to current disaster related problems. Techniques include active listening, problem solving, placing reactions in perspective, advocacy, referrals and education. Common, normative reactions to different stages of a disaster are emphasized as are stress management and other coping strategies. Relevant written materials for adults and children supplement and validate counseling. Some of these mental health activities may be referred to as "Crisis Intervention," "Debriefing" or "Defusing."

American Red Cross Services, including Mental Health, are available throughout the United States and its territories. The New York metropolitan area is covered by four main chapters: The American Red Cross in Greater New York (877-RED CROSS) covers the five boroughs of New York City plus Rockland, Orange, Putnam and Sullivan Counties. Other chapters are in Westchester, (914-946-6500), Nassau County (516-747-3500) and Suffolk County (631-924-6700).

Dorothy Brier, CSW, ACSW, is Chairperson of Disaster Mental Health Services at the American Red Cross in Greater New York and Mary Tramontin, Psy.D., is a Leadership Volunteer with Disaster Mental Health Services, American Red Cross in Greater New York, ser-and has a private practice in Chappaqua, New York.

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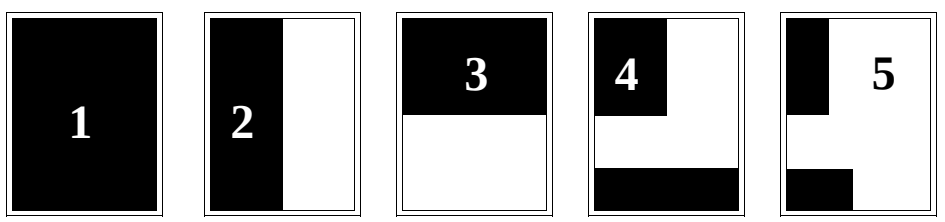

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