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WINTER 2009 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 11 NO. 1

Understanding and Treating Posttraumatic Stress Disorder

By the National Center for Posttraumatic Stress Disorder US Department of Veterans Affairs

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder that can occur after you have been through a traumatic event. A traumatic event is something horrible and scary that you see or that happens to you. During this type of event, you think that your life or others' lives are in danger. You may feel afraid or feel that you have no control over what is happening.

Anyone who has gone through a life-threatening event can develop PTSD. These events can include: combat or military exposure, child sexual or physical abuse, terrorist attacks, sexual or physical assault, serious accidents such as a car wreck, and natural disasters such as a fire, tornado, hurricane, flood, or earthquake.

After the event, you may feel scared, confused, or angry. If these feelings don't go away or they get worse, you may have PTSD. These symptoms may disrupt your life, making it hard to continue with your daily activities.

How Does PTSD Develop?

All people with PTSD have lived through a traumatic event that caused them to fear for their lives, see horrible things, and feel helpless. Strong emotions caused by the event create changes in the brain that may result in PTSD.

Most people who go through a traumatic event have some symptoms at the beginning. Yet only some will develop PTSD. It isn't clear why some people develop PTSD and others don't. How likely you are to get PTSD depends on many things. These include: how intense the trauma was or how long it lasted; if you lost someone you were close to or were hurt; how close you were to the event; how strong your reaction was; how much you felt in control of events; and how much help and support you got after the event.

Many people who develop PTSD get better at some time. But about 1 out of 3 people with PTSD may continue to have some symptoms. Even if you continue to have symptoms, treatment can help you cope. Your symptoms don't have to interfere with your everyday activities, work, and relationships.

What Are the Symptoms of PTSD?

Symptoms of posttraumatic stress disorder (PTSD) can be terrifying. They may disrupt your life and make it hard to continue with your daily activities. It may be hard just to get through the day.

PTSD symptoms usually start soon after the traumatic event, but they may not happen until months or years later. They also may come and go over many years. If the symptoms last longer than 4 weeks, cause you great distress, or interfere with your work or home life, you probably have PTSD. There are four types of symptoms: reliving the event, avoidance, numbing, and feeling keyed up.

Reliving the Event

Bad memories of the traumatic event can come back at any time. You may feel the same fear and horror you did when the event took place. You may have nightmares. You even may feel like you're going through the event again. This is called a flashback. Sometimes there is a trigger: a sound or sight that causes you to relive the event. Triggers might include: hearing a car backfire, which can bring back memories of gunfire and war for a combat veteran; seeing a car accident, which can remind a crash survivor of his or her own

see Overview of PTSD on page 34

Columbia Trauma and PTSD Program: Vital Research and Treatment for Veterans

By Matthew J. Kaplowitz, MA Clinical Researcher and Project Coordinator for War Veterans Columbia Medical Center/NYSPI

Those of us who have not had the misfortune of enduring war find it difficult to understand. Popular culture is rife with images of warfare, but nothing in civilian life actually compares to the experiences of combat. Combat stress includes not only the constant threat of injury and death, the horrors of witnessing violent death, and the moral ambiguity of killing others, but also an unrelenting accumulation of emotional and physical pressures: sleep deprivation, illness, the ongoing noise and impact of shell blasts, the stench of viscera, friendly fire, separation from loved ones, malnutrition, sexual assault, and so on, permeating one's mental faculties 24/7, often to the point of injury.[1]

Combat veterans, therefore, represent a special group of individuals, unique in what they do and what they experience, as well as the subsequent burden they bear. One such veteran, Yuval Neria, PhD, has devoted his professional life to understanding extreme exposure to trauma including combat and war captivity, and its psychological consequences.[2,3,4,5,6,7]

"Research has improved our understanding of traumatic injuries by reliably defining diagnoses and documenting a range of long-term consequences," said Dr. Neria. "But research has yet to provide a comprehensive psychobiological explanation for trauma related injuries, and we are just beginning to understand the different forms of war-related trauma."

Dr. Neria, who served in the Israeli army in the 1973 Yom Kippur War, was injured and awarded the Medal of Valor, equivalent to the Congressional Medal of Honor. He is Director of the Trauma and PTSD Program at Columbia University Medical Center, Department of Psychiatry, and the New York State Psychiatric Institute (CUMC/NYSPI), where he is developing a state-of-the-art research and treatment program for returning war veterans.

"War breeds more than just fear; for example, war also confronts servicemen with an intensity of aggression, in others and themselves, which may differ from anything experienced in civilian life. This has a psychological "scarring" effect on certain soldiers. Other veterans are fixated on the loss of a buddy and suffer from traumatic grief.[7] Some are more depressed, without any one outstanding trauma, yet worn down by operational stress to the point of being traumatized." He added, "It's imperative that we try to understand how to treat these various aspects of trauma, each of which deteriorates into the 'downward spiral' of PTSD."

Post-traumatic Stress Disorder (PTSD)

Post-traumatic stress symptoms are many and varied. Symptoms may include vivid recurring memories of the trauma, severe anxiety, jumpiness, irritability and emotional withdrawal from friends and family, uncontrollable outbursts of anger, powerful urges to avoid any reminder of the trauma, and difficulty functioning from day to day.

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Mental Health News

Upcoming Theme and Deadline Calendar

Spring 2009 Issue:
"Follow-up Care After Psychiatric Hospitalization"
Deadline: February 1, 2009

Summer 2009 Issue:
"Recovery and The Consumer Movement"
Deadline: May 1, 2009

Fall 2009 Issue:
"Helping Couples Cope With Crisis"
Deadline: August 1, 2009

Winter 2010 Issue:
"Understanding and Treating Schizophrenia"
Deadline: November 1, 2009

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MENTAL HEALTH NEWSDESK

Transcranial Magnetic Stimulation More Effective For Depression in Those with Less Medication Resistance

Staff Writer
Mental Health News

In a study of Transcranial Magnetic Stimulation (TMS) for depression published online this week in the journal Neuropsychopharmacology, researchers reported that patients suffering from major depression were more likely to benefit from TMS if they had failed to respond to one antidepressant medication in their current episode. This pivotal study, noted the paper's authors, provides critical information regarding the patient population for whom TMS is likely to be most effective.

Lead author on this report, Dr. Sarah Lisanby, Director of the Division of Brain Stimulation and Therapeutic Modulation in the Department of Psychiatry at Columbia University and New York State Psychiatric Institute (NYPSI), was the principal investigator of the NYSPI site, one of 23 international centers involved in the study. A total of 301 patients were randomized to real TMS or sham in the first phase of the study. The second phase, an extension of the first that lasted six weeks, provided real TMS to patients who had participated in the first phase for at least four weeks and had not improved significantly.

Sarah Lisanby, MD

"A total of 164 patients had received one antidepressant treatment trial of adequate dose and duration in the current episode, with the remainder of the patients receiving from two to four adequate treatment trials," the authors wrote. Results showed that a lower degree of medication resistance predicted better antidepressant response to TMS, a finding that is consistent with earlier reports that medication resistance was a predictor of response to medications.

Prior studies had identified a number of factors that predicted response to TMS, including duration of current episode of depression and severity of illness at baseline. The current multi-site study found that improved response was associated with shorter illness duration as well as greater severity of depression at baseline.

Treatment parameters in this study established a repetition rate of 10 pulses per second (10 Hz) for a total of 3000 pulses in each treatment session to the left dorsolateral prefrontal cortex.

"These results may be useful in guiding patient selection, for the design of future studies on the clinical efficacy of TMS, and also in defining the appropriate phase of illness for which TMS would be most effective," the authors concluded.

TMS is an investigative device that holds promise for the treatment of psychiatric disorders including depression. The ability of TMS to non-invasively stimulate specific brain regions without the need for anesthesia would make it an attractive alternative when medications fail, should the device become available for the treatment of depression.

Dr. Lisanby is Chief of the Columbia Brain Stimulation and Neuromodulation Division and Professor of Clinical Psychiatry. This Division focuses on the use of emerging electromagnetic means of modulating brain function to study and treat psychiatric disorders. These techniques include transcranial magnetic stimulation (TMS), vagus nerve stimulation (VNS), magnetic seizure therapy (MST), deep brain stimulation (DBS), transcranial direct current stimulation (tDCS), and electroconvulsive therapy (ECT).

Dr. Lisanby became internationally recognized as a leader in the field of TMS when her research team innovated the use of TMS to perform a safer version of convulsive therapy—a procedure termed Magnetic Seizure Therapy (MST). She is the Chairperson of the American Psychiatric Association Task Force on ECT, the President of the International Society for Transcranial Stimulation, immediate past President and Fellow of the Association for Convulsive Therapy, and a Member of the American College of Neuropsychopharmacology, among others. Dr. Lisanby is the recipient of over 35 honors and awards, including the Gerald L. Klerman Award presented by the National Alliance for Research in Schizophrenia and Depression, and the 2004 Max Hamilton Memorial Prize of the Collegium Internationale Neuro-Psychopharmacologicum (CINP).

JBFCS Foster Care Initiative Celebrates Power of Partnership

Staff Writer
Mental Health News

On the morning of September 25, 100 members of the community gathered at the Jewish Board of Family Children's Services (JBFCS) in Manhattan to recognize the Foster Care Mental Health Initiative and the power of partnership.

The Foster Care pilot project was initiated in 2005 by JBFCS together with Good Shepherd Services, a foster care agency to explore the viability of bringing mental health support to family foster care agencies. As a result of placing mental health services on-site where children and their foster families are being served, the rate of transfers of children within foster care has been dramatically lowered.

The pilot between JBFCS and Good Shepherd Services has now expanded to five partnerships between mental health agencies and foster care agencies in New York City, including the ongoing collaboration between JBFCS and Good Shepherd.

This work addressed the needs of foster care children requiring mental health treatment because of past trauma of abuse and neglect. The JBFCS Center for Trauma Program Innovation is training the partner mental health and foster care agencies in Trauma Systems Therapy to enhance their skills in providing trauma-focused assessment and treatment services.

Special guests from the New York State Office of Mental Health are Commissioner Michael Hogan, Deputy Commissioner David Woodlock and Anita Appel, Director, New York City Field Office with JBFCS staff Paul Levine and Carmen Collado and JBFCS Board members David Sweet and John Herrmann

The event was emceed by JBFCS Executive Vice President and CEO Paul Levine. He thanked the partners in this effort giving special recognition to the New York State Office of Mental Health Commissioner Michael Hogan and Deputy Commissioner David Woodlock as well as Anita Appel, Director, New York City Field Office. Levine also acknowledged the Council of Family and Child Caring Agencies and the Coalition of Behavioral Health Agencies.

Bronx Borough President Adolfo Carrion, New York City Councilman Bill de Blasio, Assemblyman (D-Bronx) Peter Rivera, and New York City Comptroller William Thompson, Jr. recognized Levine for his leadership role in helping create this innovative model of care.

Melissa Russo, Anchor and Government Relations Reporter, WNYC-TV/ News 4 New York received a Media Recognition Award for her passionate commitment to reporting stories that highlight services benefiting New York City children, particularly in the child welfare system.

Jewish Board of Family and Children's Services provides a comprehensive network of mental health and social services which promotes well-being, resilience and self-sufficiency for individuals and families at every stage of life. We help people of all faiths, races and cultures throughout New York City and in Westchester.

MENTAL HEALTH NEWSDESK

New York to Develop Strategies to Assist Returning Veterans and Their Families

Will Create Public-Private Collaborative Efforts to Improve Services

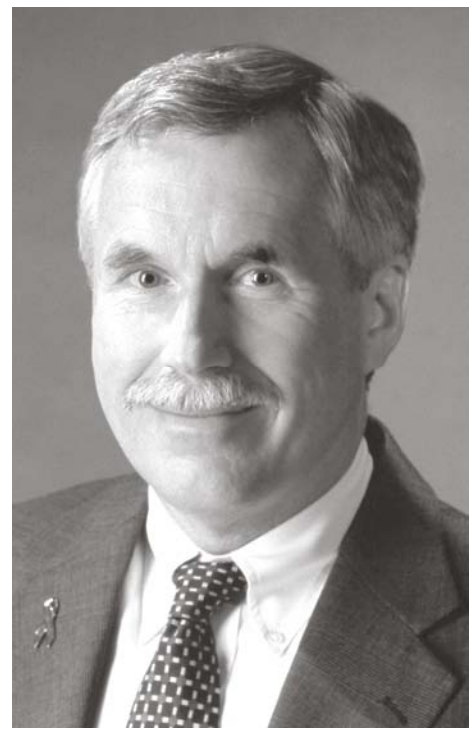
Staff Writer
Mental Health News

Governor David A. Paterson recently announced that New York was one of nine states and one territory that participated in the National Policy Academy for returning veterans; a public-private collaborative aimed at developing strategies to improve services provided to returning veterans needing assistance with human, social and economic challenges.

"Our men and women in military service place their lives on the line to protect New Yorkers and all Americans. When they return home, we must ensure that they and their families have the necessary services and support they need to readjust to everyday life," said Governor Paterson. "This public-private partnership, that crosses service systems lines, will guarantee that the challenges our returning veterans and their families face are addressed."

As the first step to improve coordination of services, leaders from public and private service agencies in New York State met with federal leaders and similar teams from the participating states August 11-13, 2008 in Bethesda Maryland, to develop comprehensive strategies in assisting returning veterans and their families. The National Policy Academy was coordinated and sponsored by the federal Substance Abuse and Mental Health Administration (SAMHSA), the Department of Defense (DOD), and the Department of Veterans Affairs (VA).

Governor David A. Paterson



Michael F. Hogan

During three days of workshops, panel discussions and working sessions, New York State team members explored new approaches for helping returning veterans and their families address problems and concerns in such areas as finances and insurance, family relationships, health and mental health care, substance abuse issues, employment, and complex medical injuries.

New York's team included representatives from the Captain Timothy J. Moshier-Memorial Foundation, Samaritan Village Inc.; Jefferson County Community Services; Office of New York State's Deputy Secretary for Health and Human Services; New York State Offices of Mental Health and Alcoholism and Substance Abuse Services; New York State Departments of Health and Labor; New York State Divisions of Veteran Affairs and Military and Naval Affairs; and the United States Department of Veterans Affairs.

Jim McDonough, Director of the New York State Division of Veterans' Affairs, said: "The development of a comprehensive strategy to help returning veterans and their families has been one of our highest priorities. I am pleased with New York's leadership in this effort and pledge to do our very best so that veterans and their families find 'no wrong door' when it comes to accessing benefits and services."

Major General Joseph Taluto, Adjutant General, Division of Military and Naval Affairs, said: "The Division of Military and Naval Affairs is continually seeking

see Strategies on page 26

Bridging Clinical and Research Frontiers in the Treatment of PTSD

By Christie Jackson, PhD, Kate R. Kuhlman, BA, and Marylene Cloitre, PhD
Institute for Trauma and Resilience, NYU Child Study Center

Posttraumatic Stress Disorder (PTSD) is a debilitating stress-related psychiatric condition associated with significant psychiatric comorbidity, functional impairment, compromised health status, early mortality, and substantial economic costs to society.

Despite the efficacy of cognitive-behavioral therapies for treating PTSD, there is relatively little evidence of adoption of these treatments into the community. Clinicians note that interventions do not typically ameliorate the significant interpersonal and emotional management disturbances found in individuals with PTSD and cite concerns related to the potential risk of increased dropout from exposure-based treatments.

At the NYU Child Study Center Institute for Trauma and Resilience, we seek to bridge this gap between clinical services and research findings. We are working toward this goal in three ways: by conducting research studies evaluating the efficacy of various treatments for PTSD, by training clinicians in the effective implementation of empirically sound interventions, and by providing direct clinical services to individuals and families affected by trauma.

Dr. Marylene Cloitre, Director of the Institute, recently concluded an NIMH funded R01 randomized controlled trial testing a two-phase, sequential therapy called Skills Training in Affective and Interpersonal Regulation with Modified Prolonged Exposure (STAIR-MPE). The first phase, skills training, focuses on improvement in day-to-day functioning while the second, a modified version of prolonged exposure, focuses on the processing of traumatic memories. The results of the clinical trial indicate that the sequential combination of skills training followed by emotional processing work addresses many of the aforementioned concerns of clinicians and suggest that STAIR-MPE may be effective in community settings.

In our current research, we are comparing the efficacy of STAIR versus the SSRI medication sertraline (Zoloft) for individuals with PTSD related to sexual trauma. In addition to the scientific value of the research, this treatment study meets a community need by offering free therapy to individuals who meet criteria for the study, and appropriate treatment referrals to those who do not. Our participants are adults (ages 18-56) living in and around New York City with either child and/or adult sexual trauma histories. Participants are administered a full clinical evaluation and participate in an fMRI scan of the brain before and after receiving their treatment of choice. Each participant has the option of receiving 16 sessions of cognitive behavioral therapy (STAIR-MPE) or medication treatment. Dr. Christie Jackson is the Project Director for this study, and supervises the administration of STAIR. The SSRI arm is administered by Dr. Anthony Charuvastra, a psychiatrist mentored by Dr. Cloitre toward a research career in trauma-related psychiatric disorders. Study participants receive sertraline (Zoloft) in an open, flexibly dosed schedule designed to mimic typical clinical practice. Participants have weekly visits to assess their response to medication and address any side effects or other obstacles to treatment.

The neurobiological directive of the study is to examine the emotion regulation systems in the brain during Emotional Memory and Anticipatory Threat paradigms. Although the study is ongoing, a preliminary analysis of pre- and post-treatment data indicates reduced amygdala reactivity and increased right ventromedial prefrontal cortex activity during both paradigms after treatment. These neurochemical changes reflect reductions in PTSD symptom severity as measured by the Clinician Administered PTSD Scale (CAPS) and improved emotion regulation skills as measured by the Negative Mood Regulation (NMR) Scale. Individuals interested in seeking treatment through our research study may call (212) 263-2483.

Dr. Cloitre and Dr. Jackson also work to disseminate effective treatments for PTSD. They recently conducted a two-day workshop at Columbia University's New York Presbyterian Hospital for clinicians who treat individuals with histories of trauma. Dr. Cloitre has traveled throughout the world presenting findings from her research studies evaluating the

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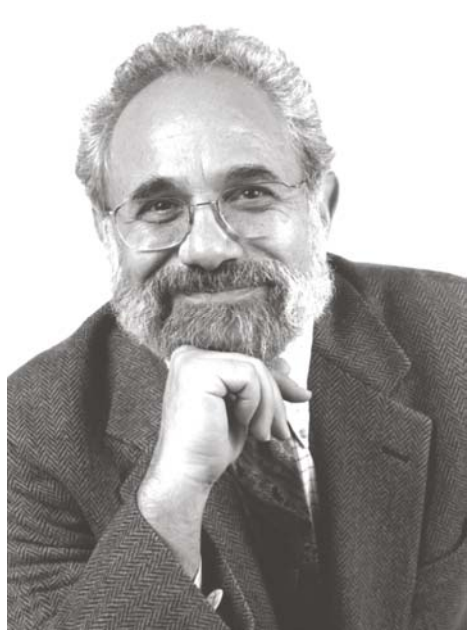
POINT OF VIEW

Preparing Communities for The Elder Boom: Mental Health Matters

By Michael B. Friedman, LMSW and Kimberly A. Williams, LMSW



Michael B. Friedman, LMSW

Kimberly A. Williams, LMSW

Happily, a number of efforts are now underway to prepare communities and the aging services system for the elder boom. Sadly, mental health doesn't figure into most of them in any significant way despite the simple and obvious fact that you cannot age well without your mental health.

The new initiatives go by such names as "livable communities," "age-friendly cities," or just "modernization." The beauty of them all is that they are not built on the ageist myth that most older adults are poor, decrepit, and disabled. Instead, they assume, what is true, that most older adults are relatively healthy (give or take a few chronic conditions), able, even skilled, experienced, energetic, and interested in getting the most out of life. So, livable communities, age-friendly cities, and other modernization initiatives focus on social and recreational opportunities, creative activities, and opportunities to be productive through paid or volunteer work. They also focus on such mundane, but very important matters as transportation, access to shopping, and affordable housing. With regard to health, they stress access to health care for all and various services and supports for those older adults who need help in order to continue to live where they want—in the community.

But mental health is barely an afterthought. Yes, there are passing references to mental health in some of these initiatives—usually to depression and Alzheimer's Disease—but the references are almost always brief and superficial.

For example, AARP's *Livable Communities: An Evaluation Guide*, an admirable document in most ways, says only that affordable mental health services should be available for people with "chronic depression" who cannot get adequate help from clergy or "friendly community members" and that, for people with Alzheimer's Disease, home health and day care programs are useful and that freestanding nursing homes may be necessary for those who cannot afford continuing care communities.

Obviously, this is not all that needs to be included in a livable community or an age-friendly city to respond to the mental health needs of older adults. What else should be available?

Information and referral about geriatric mental health as well as long-term care services is a very important resource for individuals and families who are often at a total loss when it comes to mental health problems. This should include telephonic crisis intervention, particularly suicide prevention, since older adults are more likely to take their own lives than any other population.

Mental health education in community settings is also very important so that older adults and their families can learn what mental illness is, that it can be successfully treated, and where to turn for help.

Mental health maintenance and promotion activities, such as the kinds of recreational, social, and vocational activities included in most modernization initiatives, are important to help older adults maintain or recover their mental health. There are also new products available, some of which may be effective, to improve or at least maintain cognitive functioning as one ages.

Mental health services integrated into primary health care practices are essential to help the majority of older adults who go to their family doctors first for help. Although some providers are quite skilled, mental and substance use disorders usually go undetected and untreated or are treated inappropriately in primary care practices. Screening for mental and substance use disorders and having mental health professionals on-site who follow up with patients being treated for mental illness both contribute to positive outcomes.

Mental health services integrated with home health care, including screening, referral, and in-home intervention can result in improved care and reduction of placements in nursing homes.

Adequate mental health services in assisted living facilities and in nursing homes result in improved quality of life for individuals and for others living in the same facility. Some of these facilities provide good care, but there is a widespread consensus that mental health needs are usually not addressed well.

Housing alternatives to nursing homes especially for people with co-occurring serious physical and mental health problems are needed and could reduce the number of unnecessary placements in nursing homes and provide continuity of caring relationships, especially for those who are currently served in mental health facilities.

Support for family caregivers, who provide 80% of the care for people with disabilities and who are at high risk for depression, anxiety, and physical illness reduces mental and physical illnesses and delays nursing home placements by up to 18 months. Family support is needed for working age adults caring for aging parents, older adults caring for grown up mentally disabled relatives, and grandparents raising grandchildren.

Accessible and affordable mental health treatment services, particularly services in people's homes and in community settings to which they go for other purposes such as houses of worship and senior centers, could result in older adults and their families getting needed treatment they are likely not to get currently.

Mental health services should be integrated into aging services programs such as adult protective services, senior housing, naturally occurring retirement communities (NORCs), social adult day care, and senior centers. These settings offer opportunities for screening, referral, on-site treatment, and even on-site integrated physical and mental health services.

Culturally, as well as clinically competent mental health services, including services in the client's primary language, are critical to be able to adequately serve people from minority cultures, whose numbers are growing rapidly.

Older adults can be good service providers for other older adults who have mental health or substance use problems. Communities should be making efforts to engage older adults in help-providing roles. This includes retired professionals and paraprofessionals and retired people who need to learn new skills and have special roles in order to be helpful to their peers.

It is unfortunate that mental health services and supports of the kind noted above are not included in efforts to develop communities that are conducive to living well in old age. Including them, we believe, vastly increases the likelihood that older adults of the next generation will age well. Hopefully, the structural blinders, stigma, and ageism that now result in the neglect of mental health will fall away soon, before it's too late to meet the mental health challenges of the elder boom.

Michael B. Friedman is the Director of the Center for Policy, Advocacy, and Education of The Mental Health Association of New York City. He is also Chair of the Geriatric Mental Health Alliance of New York. Kimberly A. Williams (formerly Steinhagen) is the Director of Advocacy for the Center and Director of the Geriatric Mental Health Alliance. The opinions in this article are their own and do not necessarily represent the opinions of The Mental Health Association. They can be reached at center@mhaofnyc.org.

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efficacy of STAIR-MPE and teaching clinicians how to implement STAIR in their own practices. Both Dr. Cloitre and Dr. Jackson are actively supervising clinicians-in-training in the effective treatment of trauma-related disorders. Dr. Cloitre and colleagues recently published Treating Survivors of Childhood Abuse: Psychotherapy for the Interrupted Life, a treatment manual for clinicians who work with individuals with histories of chronic interpersonal trauma.

The final goal of the staff of the Institute for Trauma and Resilience is to offer high-quality direct clinical services. We work with children, adolescents, and adults who have experienced traumatic events such as the loss of a loved one, a motor vehicle accident, acts of terrorism, physical assault, sexual assault and other forms of interpersonal violence. The Institute provides evaluation, consultation, and treatment for individuals who are concerned about the possible effects of such events on their children, themselves or family functioning. The services provided are specifically tailored to the individual's or family's needs and include academic and psychological evaluation, cognitive-behavioral therapy, medication, skills building and resilience enhancement. State-of-the-art treatment approaches that are grounded in empirical support and have demonstrated efficacy in treating survivors of stressful events are offered. If you are interested in learning

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The NYSPA Report:

Taking Care of the Mental Health Needs of Active Duty Military, Veterans and their Families

By Mary Helen Davis, MD
Director of Behavioral Oncology
Norton Cancer Institute

The prolonged war experiences and multiple deployments of men and women to Iraq and Afghanistan have created emotional as well as physical casualties of war. While more than 4,000 U.S. soldiers have lost their lives in the recent conflicts, multitudes of others have experienced life-altering consequences. Traumatic Brain Injury, often described as the signature wound of this war, has impacted many soldiers exposed to countless blast injuries. The war experience has left many soldiers suffering from depression, anxiety, post traumatic stress disorder, chemical dependency and other issues. These sometimes invisible injuries of war may go undetected until the veteran returns home. As the soldiers readjust to home life, other problems may arise in the form of sexual assault and domestic violence.

It has been estimated that as many as 20% of active duty military and perhaps 40% of reserve soldiers returning from combat may have a mental illness. In addition, many soldiers and their families will face post-deployment adjustment problems and challenges. Understanding and addressing these normal stressors can perhaps prevent or decrease the likelihood of more serious mental health issues. In addition to learning more about TBI, PTSD and other sequela of war, helping these soldiers cope can help us better understand aspects of resilience and recovery.

The American Psychiatric Association is committed to assisting in the care of veterans and their families as well as advocating for their mental health needs in Washington. The APA has supported the caucus of psychiatrists who work within the VA system, in addition to forming numerous work groups such as the Committee on Mental Healthcare for Veterans, Military Personnel and their Families. APA members have been encouraged to participate in "Give an Hour," a volunteer program to match mental health providers with post deployed military members and their families. In addition, both the American Psychiatric Association as well as the APA Foundation has supported research efforts to better understand the barriers that military members face in seeking mental health care as well as looking at use of evidence based therapies in treating PTSD.

There exists a spectrum of stressors in the cycle of predeployment, deployment, reunion, and readjustment. Preparation for war or deployment can impact families as they anticipate differing roles and responsibilities, manage uncertainty, and experience anticipatory anxiety. Positive emotions may also exist in terms of pride and patriotism. Post deployment, with much anticipated reunions, can come with its own set of stressors and adjustments.

Whether we look at the spectrum of symptoms of distress or disorder, it is clear that the mental health consequences

Mary Helen Davis, MD

of the war are substantial. The systems of care, whether through the military, Veterans Health Administration or civilian treatment facilities, must include family in the treatment process. Ideally treatment should be integrated, involving community resources such as schools, churches, and employers. Issues of stigma must be overcome so that both veterans and their family have access to care without fear of repercussions in terms of their career, employment, or future insurability.

A recent American Psychiatric Association survey of military service members who had served in a war zone or in support of a war zone in the previous five years believed that stigma continues in the military. About 3 in 5 military members said seeking help for mental health concerns would have a negative impact on their career. More than half of the spouses said seeking help for their own mental health concerns could impact their spouse's career.

The Department of Veterans Affairs reports that only 40% of returning veterans eligible for services seek treatment through the VA. Furthermore the VA traditionally has not extended care to families and children. The APA survey showed military spouses, who experience their own stressors from repeated deployments and homecomings, believe it's harder for them to get mental health care within the military system than in civilian life. Clearly there are numerous areas of unmet needs, with much of treatment occurring in the community. Community providers may need training to understand military culture and to learn about the resources that are available to help military members and their families cope with the anticipated stressors of deployment and reunion. Approximately 40 states offer a 211 number to help individuals locate appropriate health and human services.

On the advocacy front, the APA has testified at congressional hearings supporting the validity of Post Traumatic Stress Disorder as a diagnosis, recognizing the effectiveness of treatment, providing information on the problems of co-occurring and substance use disorders, lobbying for more funding for research and supporting of workforce issues and access to quality care. In the 110th Congress, there were nearly one hundred bills introduced with veterans and health in their title. Although limited legislation has passed, there have been significant funding increases regarding veterans' health. The level of national attention has brought substantial change in the delivery of care and the efforts to create a continuum of care. This level of national attention and concern must be followed with action to address access to care issues and to bring effective and evidence-based treatment to our veterans in the communities in which they live.

Mental health treatment has historically been underfunded. It usually takes a crisis to bring attention to the deficits in mental health delivery systems in order to spark an interest in demanding adequate funding (take for example the state of Virginia expanding funding for mental illness in the aftermath of the deadly shooting at Virginia Tech in 2007). Hopefully, recognition of the public health crisis created by the current war and the attention drawn to mental health issues will be a stimulus to providing adequate mental health care for all.

Dr. Davis is the Director of Behavioral Oncology at the Norton Cancer Institute in Louisville, Kentucky. She is a member of the American Psychiatric Association's Board of Trustees and serves on the APA's Committee on Mental Health of Veterans, Active Duty Military and Their Families.

PTSD Internet Resources:

American Psychiatric Association's Healthy Minds: www.healthyminds.org

The Center for the Study of Traumatic Stress: www.centerforthestudyoftraumaticstress.org

Sesame Street Workshops: www.sesameworkshop.org

Military OneSource www.MilitaryOneSource.com

United States Department of Veterans Affairs: www.va.gov

The National Center for Posttraumatic Stress Disorder: www.ncptsd.va.gov

Give an Hour: www.giveanhour.org

The Economics of Recovery

How Consumers Can Help Close the Budget Gap

By Donald M. Fitch, MS
Executive Director
Center for Career Freedom

Speaking before the Greater New York Hospital Association, Governor Paterson said the only way to solve the multi-billion dollar budget crisis was by "--working collaboratively -- whether we run the hospital, work in the hospital or have been hospitalized."

While the Government could freeze hiring, the unions could delay their raises and pharmaceuticals could cut profits. What could consumers do to be more productive?

Many years ago at the Center for Career Freedom's weekly community meetings, we saw a potential for channeling our consumer's anger, frustration, and chronic complaining into a think-tank which focused on practical ways of solving their problems. The goal was to develop actionable, street-smart solutions that bring closure to the critical issues of accessing Government services such as obtaining quality health care, finding safe and affordable housing, find decent jobs, and more.

Over time, we developed a Consumer Solution Team consisting of a group leader, internet researcher, and graphic artist. The process begins with compiling problems generated through focus groups, which are then quantified using opinion surveys to identify those issues that are most important to most consumers, most of the time. Solution-concepts are then developed and field tested (few ideas survive this gauntlet to become a prototype for field testing). Following the field test, the prototypes are further refined, reverified and then produced and distributed to consumers, government, and community agencies via postal mail and email on a pro bono basis.

We have found that most of our consumer's questions can be answered by surfing government and community

Donald M. Fitch, MS

agency data bases on the internet. Other issues require us to track down and interview a variety of government regulation experts. These Consumer Solution Teams have developed a series of visual tools that comprise our "Case Manager's Toolkit." Three of our latest tools are highlighted below. Others can be found on our website: www.economcisofrecovery.org. The tools are easily adapted to other counties and populations.

Where to Find Decent Affordable Housing

People with disabilities and the Homeless are often trapped for years in substandard housing at enormous expense to themselves and taxpayers. While consumer surveys usually rank "Housing" as one of the most citied needs, few consumers know their options and how to access them. The "Case Manager's Housing Guide" was developed to meet this need.

The "Guide" enables Case Managers to refer consumers to up to eight housing options here in Westchester County, New York. It summarizes the essentials: eligibility criteria, key services, monthly rent, average wait time, and where to apply. Required documentation, earned income caps, and a summary of Government benefits is included on the reverse side.

This information was gathered from government and community housing websites and then reviewed by the respective agencies in the summer of 2008. Annual updates are planned to reflect the usual 2% - 3% cost of living allowances (COLA) for HUD's rent subsidiaries, SSI, SSDI, and Food Stamps.

Our field tests found that use of the "Guide" significantly reduced housing placement times and promoted stabilization in the community.

Keeping Track of Your Prescriptions

The "Prescription Record" wallet card provides accurate, vital medical data for health care professionals at intake or in an emergency. Information on medications and dosages, medical alerts, emergency contacts and government benefits are then readily available when needed.

Craigslist.org: Where the Jobs Are

For years, and with limited success, the Center spent hundreds of hours and dollars ferreting out part-time jobs for students who graduated from our in-house "Microsoft Office Training Certification Program." Like other vocational programs, we regularly scanned our area's *Journal News* newspaper's classified section, *The Penny Saver*, and monster.com, etc. We even conducted cold call outreach campaigns using the yellow pages (we focus on part-time jobs because most of our students are on SSI/SSDI disability which limits how much they can earn).

We were frustrated by our poor success and lack of productivity and decided to conduct a study in hopes of finding a more efficient way of locating these elusive part-time jobs.

We collected, tabulated and charted a week's worth of *Journal News* classifieds, all versions of the weekly *Penny Saver*, and seven days of craigslist.com job listings for Westchester County. The print ads were then crosschecked against their respective websites and all three lists were reviewed to remove duplicates, expired ads, out-of-county ads, and obvious advertisements.

We were amazed at what we learned; the www.craigslist.org site contained over eight-hundred jobs, four-hundred fifty part-time – ten times more than the *Journal News* or *Penny Saver*, (the "Where to Find Jobs" chart below explain the data). Also, job seekers can post their resumes on line, free, for thirty days.

Visual Tools

These deceptively simple, inexpensive visual tools can reduce the Case Manager's wasted motion and service response time by liberating information that has too long been imprisoned in binders, reports, and data bases. In business and Government, visual tools have been found to significantly increase employee productivity and transform dysfunctional work cultures by uncovering and sharing critical information that would otherwise be hoarded by managers, protected by workers, or that simply gets lost in the intake and referral process.

There are thousands of consumers in New York State that are willing and able to help "fix our broken system" by helping to create and utilize effective visual tools. Please support them so they may do their part to help close the budget gap.

For hard copies of these tools, please call Joanne: 914-288-9763. For an email version, email: joanne_casa@yahoo.com.

THE MENTAL HEALTH LAWYER

The Legal Case in Support of Veterans Suffering with PTSD

By Carolyn R. Wolf, Esq
Douglas K. Stern, Esq
and Eric Broutman. Esq
Abrams, Fensterman, Fensterman, Eisman, Greenberg, Formato & Einiger, LLP

Initially referred to as being "shell shocked" and now properly diagnosed as Post Traumatic Stress Disorder (PTSD), soldiers returning from combat often suffer from severe psychological injuries as a result of horrific experiences they were exposed to. Today, with this country engaged in two wars and millions of men and women in military service in each of these theaters of combat, the concern for soldiers with PTSD is greater than ever.

Initially, this article will explore the expansive nature of the problem posed where so many of our military men and women return with psychiatric wounds after their time in combat. This article will go on to examine the first of its kind class action lawsuit, Veterans for a Common Sense v. Peake, which seeks to challenge the federal government's failure to provide adequate treatment for those soldiers suffering with PTSD and other combat related psychiatric difficulties.

Veterans and PTSD

It is estimated that anywhere from 15% to 50% of troops returning from Iraq and Afghanistan suffer from PTSD in one form or another. One researcher places a conservative estimate of 300,000 psychiatric casualties from service in Iraq alone. The estimated cost of treatment for these Iraq veterans is in the range of $660 billion, which is greater than the total cost of the war itself ($500 billion). As evidence of this, a study done of the first 100,000 Iraq and Afghanistan veterans treated at Veterans Administration ("VA") facilities showed that 25% of them received a mental health related diagnosis, and over half of these soldiers suffered from two or more diagnoses. With numbers this expansive it is not difficult to recognize the strain this will place on mental health resources and professionals alike.

However, studies also show that one of the most challenging problems is getting soldiers the treatment they need at an early stage before PTSD can become entrenched and cause increased psychological damage. Evaluations of soldiers completed immediately after return from combat show that about 5% of soldiers show significant mental health problems. This number jumps to 27% for active duty soldiers and 42% for reserve soldiers three to six months after return. Researchers and clinicians conclude that the reason for this dramatic increase is twofold. First, soldiers want nothing more than to come home to family and friends and they fear that if they admit that they are having psychiatric difficulties this will

Carolyn R. Wolf, Esq

delay their homecoming. Second, PTSD and other psychiatric conditions often have a delayed onset.

While symptoms of PTSD vary greatly from individual to individual, some of the more insidious symptoms are a re-experiencing of traumatic events, difficulty sleeping and concentrating, and an inclination toward irritability and violence. These horrific symptoms, and the grand scale on which they are affecting returning veterans, has caused something of an epidemic relating to suicide attempts and acts. Some estimates show that 1,000 soldiers attempt suicide every month and 18 a day are successful. Simply put, these numbers are staggering.

A veteran seeking treatment with the VA must file a disability claim with one of 58 regional offices across the country. The proceedings at the VA that determine if the soldier has a valid disability claim are meant to be non-adversarial. Soldiers are not allowed to pay an attorney for assistance, demand evidence or compel people to testify. After the initial stage, if the veteran is displeased with the outcome, the soldier may file an appeal with the Board of Veterans Appeals, which can in turn, be appealed to the United States Court of Appeals for Veteran Claims.

Veterans for Common Sense v. Peake

In July of 2007, Veterans for Common Sense and Veterans United for Truth, two veteran's advocacy groups, filed suit on behalf of all soldiers against James B. Peake, the Secretary of Veterans Affairs. The lawsuit alleged that veterans returning from our two present wars, as well as veterans from previous military engagements, were not receiving the treatment they were due for mental health related issues. Specifically, the lawsuit claimed that the VA's treatment of veterans violated their constitutional as well as other federally protected rights. The lawsuit cited a backlog of up to 600,000 disability cases and that initial claims were often delayed as long as 160 days. The lawsuit complained of a shortage of mental health related treatment programs particularly for PTSD. Furthermore, and perhaps the most striking allegations, were that the VA was classifying genuine cases of PTSD as a "pre-existing personality disorder" to deny veterans disability claims. A spokesperson for the lawyers representing the plaintiffs made reference to the VA's motto, taken from Abraham Lincoln's second inaugural address, which is "to care for him who shall have borne the battle and for his widow and orphan." The spokesperson went on to indicate that "The VA is not living up to their motto or its obligation to care for our disabled veterans."

Initial attempts by the government failed to dismiss the lawsuit on a number of legally technical grounds. But perhaps the most striking tactic was the government's claim that the law did not require it to provide care to returning veterans, but merely that the VA was to provide whatever treatment it could in light of available financial resources. The Court quickly rejected this argument and ruled that for veterans who have returned from combat in 1998, or after, the law requires that these soldiers receive mandatory health care for up to two years following their leave of service. In all, the government's attempt to dismiss the lawsuit before it even started was unsuccessful and the lawsuit proceeded to a hearing where the Court could examine the merits of the case.

At the hearing, held in April of this year, a number of stunning facts were revealed. An Inspector's General report in May of 2007 concluded that the VA's mental health plan, which called for an immediate evaluation within 24 hours of a soldier's request for an evaluation or referral for mental health services, had not been implemented system wide. The Director of the Seattle VA Psychiatric Emergency Services indicated that his hospital faced a "tsunami of medical need" as a result of the influx of psychiatric patients returning from Iraq and Afghanistan. The most striking revelations, however, were exposed in email communications. One email was from a VA psychologist who was instructing mental health counselors to minimize diagnoses of mental disorders in soldiers. Other emails speaking of the alarming number of suicide attempts and more tragically, success amongst soldiers, sought to hide or minimize these facts. An email from the VA's chief communications officer stated "I don't want to give CBS any more numbers on veterans' suicides or attempts than they already have,

see Legal Case on page 38

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Recent Innovations in the Treatment of Posttraumatic Stress Disorder

By Judith Cukor, PhD
and JoAnn Difede, PhD
NewYork Presbyterian Hospital

The integration of technology and medicine is creating exciting possibilities for psychiatry and the behavioral sciences. A particularly intriguing one is the marriage of virtual reality technology to established behavioral principles and interventions for the treatment of anxiety disorders in general, and specifically posttraumatic stress disorder. This article will describe the current standard of care as well as discuss these innovations and new pharmacologic studies.

Posttraumatic stress disorder (PTSD) is a type of anxiety disorder consisting of a pattern of symptoms that people may develop in the aftermath of overwhelming events involving threatened death or injury, such as military combat, personal assault, terrorist attack, natural disasters, or motor vehicle accidents. Individuals suffering from the disorder re-experience the traumatic event in a number of ways including nightmares or intrusive thoughts about the trauma. They remain alert to danger in the world, maintaining a hypervigilance to their surroundings, and may experience irritability, difficulty with sleep, or concentration. Individuals with PTSD may attempt to cope using avoidance and numbing and may isolate themselves from friends and family, and cease to participate in their usual activities.

Expert treatment guidelines for PTSD were published for the first time in 1999, recommending that cognitive-behavioral treatment with exposure therapy should be the primary therapy for PTSD. Cognitive behavioral treatment for PTSD typically offers skills to cope with the symptoms, including the use of relaxation and breathing techniques and in vivo exposure to help individuals approach situations they have been avoiding. Typical treatments also employ the use of imaginal exposure to help individuals process and metabolize their trauma experiences. During the imaginal exposure, the patient recounts the trauma experience in a detailed manner repeatedly over the course of a number of sessions. Alternatively, the patient may listen to the therapist relating a vivid description of the traumatic event. Studies have demonstrated the effectiveness of exposure in treating Vietnam combat veterans, female victims of sexual assault and mixed trauma populations as well as survivors of terrorism.

Despite the established efficacy of exposure therapy, imaginal exposure presents a predicament for some patients: effective imaginal exposure requires that patients tell their trauma to their therapists, over and over again in a manner which allows them to connect to the emotions of that day; yet avoidance of reminders of the trauma is inherent in PTSD. Hence, most people with PTSD never seek treatment, some who seek treatment refuse to engage in the treatment, and others who express willingness are unable to engage their emotions or senses, retelling an emotionless tale, reflecting their numbness. Such patients often fail to improve. This is consistent with the studies that conclude that failure to engage emotionally predicts a poor treatment outcome.

In recent years, virtual reality (VR) technology has provided a tool to enhance treatment. Computer programs simulate different environments which give the patients the illusion that they have gone inside the 3-D virtual world. The set-up employs the use of a headset which responds to an individual's head movements so that when he changes his head orientation the scenery changes. Headphones provide auditory accompaniment and often a platform may provide vibrations to increase the feeling of immersion in the environment. Most recently "smell machines" have been added that allow different aromas to be released at the push of a button, in order to engage the olfactory sense. Virtual reality therapy was first applied to the treatment of phobias and numerous studies have documented that it is an effective treatment for fear of heights, fear of flying, claustrophobia, and spider phobia.

Recent developments in virtual reality technologies have opened new vistas for the treatment of PTSD by offering patients who are unable to retell their experiences a computer-generated environment in which to encounter and master their trauma. Over the course of the exposure sessions, the patient progresses through a series of computer-generated sequences that gradually increase in intensity and detail at a pace the patient can tolerate. The virtual world is programmed so that the therapist can control what the patient experiences in the virtual world by touching pre-programmed keys on the keyboard. During the exposure segments, the therapist simultaneously views the virtual environments on a computer monitor, as the patient recounts his experience while viewing the virtual world.

VR graded exposure was first successfully applied in treatment of combat-related PTSD. Dr. Barbara Rothbaum and colleagues conducted VR treatment with a man who had served in Vietnam 26 years earlier and suffered from chronic PTSD and Major Depression. Over the course of treatment sessions he viewed a progressively detailed jungle scene and Huey helicopter scene accompanied by sound effects. The patient's clinician-rated level of PTSD dropped by 34% and his self-reported levels of PTSD decreased by 45% and these gains were maintained at six-month follow-up. The success of VR treatment for PTSD was reinforced by a study of 10 Vietnam veterans, who demonstrated a 15% to 67% decrease in PTSD at six-month follow up.

We published the first case report on the use of VR therapy to treat PTSD for individuals who witnessed the World Trade Center (WTC) attacks of September 11, 2001, followed by a pilot study conducted on 10 individuals. The WTC virtual environment was developed to allow for a graded hierarchical exposure to the sensory stimuli in the world. Over the course of the exposure sessions, the patients progress through a series of 11 sequences that gradually increase in intensity from a plane silently flying past the WTC to the entire sequence of events of that day including planes crashing into both buildings and their subsequent collapses accompanied by sounds of explosions and screaming. Patients recount their personal experiences while the events are matched in the virtual environment. Participants in the pilot study included disaster workers, non-disaster relief workers and civilians with varying levels of exposure. After 6 to 14 sessions, patients receiving treatment displayed a mean of 43% reduction in PTSD symptoms, compared to no symptom reduction in a waitlist control group. This improvement was maintained at a 6-month follow-up. Significantly, 5 of the patients had previously been treated with imaginal exposure but continued to meet criteria for PTSD.

The success of this program led to the development of an interior version of the WTC program. This second environment targets individuals who were in the towers on 9/11 and simulates their escape from the building. This program is designed to serve as a prototype for other traumas in which evacuation is necessary, including earthquakes and other natural disasters.

Most recently, the virtual reality technology has been utilized to help returning Iraqi war veterans who are suffering from PTSD. A virtual Iraq environment offers a choice of scenarios to match the veterans' experiences: patients may view an Iraqi city and marketplace or may ride through a desert in a humvee. Sounds of gunfire, explosions, radios, voices and shouts may be added along with accompanying vibrations and smells of gasoline, burning rubber or spices. These elements enhance the immersion of the patients in the environment while they retell their experiences, thereby facilitating the processing of the trauma. The first case study of an Iraqi War veteran published by Drs. Gerardi, Rothbaum and colleagues showed that a 4 session intervention reduced the patient's PTSD symptoms by 56%.

Further medical advances may enhance the effects of the virtual reality treatment with the administration of D-Cycloserine (DCS; Seromycin). DCS is an antibiotic that has been used in clinical trials over the last decade as a cognitive enhancer. It is a partial agonist at the N-methyl-D-aspartate (NMDA) receptor which is known to play an essential role in learning and memory.

In one recent study, Rothbaum and colleagues assessed the effect of D-Cycloserine (DCS) on outcome for individuals receiving VR treatment for acrophobia. They found that individuals who took a dose of DCS on the days of their VR exposure showed significantly more improvement and the improvement was evident earlier in treatment as compared to patients who did not take DCS, with 2 sessions being sufficient for the DCS group compared to 6 sessions for the controls. In our program at Weill Medical College, we are currently evaluating the effects of DCS on patients undergoing VR treatment for PTSD following the WTC attacks of 9/11/01 or the events of Iraq War. Treatment is also available for family members of returning Iraqi War veterans.

Finally, propanolol, a beta blocker commonly used to treat cardiac problems, is opening up new possibilities in the treatment of PTSD. Both animal and human studies indicate that memory is enhanced by arousal or adrenergic stimulation and that memory for arousing stimuli is impaired if beta-adrenergic receptors are blocked during the time at which the memory is formed, or consolidated. Dr. Margaret Altemus at Weill Medical College of Cornell University in collaboration with Joseph LeDoux's laboratory at New York University is currently studying patients suffering from PTSD for any trauma. By having an individual take propranolol following a traumatic memory, they hope to interfere with the automatic association between the memory of the trauma and the hyperarousal symptoms and also to lessen the frequency of nightmares and flashbacks.

These exciting innovations may provide new possibilities for individuals suffering from the debilitating symptoms of PTSD. Some may be successful in helping individuals who have not responded to traditional treatments while others may engage patients who have heretofore refused to seek help. Indeed, they are indicative of a dynamic field that is expanding its horizons in the hope of offering relief to those who are in need.

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How Will They Tell Their Story? PTSD and Substance Use Disorder

By Barry T. Hawkins, PhD, LMHC, CASAC, CATSM, Director, Chemical Dependency Services, Orange County Department of Mental Health

A few years ago, while visiting a substance abuse treatment program, I was discussing treatment protocols with the Clinic Director. A case was brought up in which the woman patient clearly had a history of traumatic abuse. When I asked how the program addressed these issues, the Director replied, "Oh we leave that stuff alone. We only have a few weeks to get them on track, and delving too deeply is just going to bring up stuff we don't have the time to deal with." I swallowed, and asked, "So then… how is she going to tell her story?" The conversation was interrupted at the time, so I didn't get an answer to my question, but the conversation alerted me to how hesitant some agencies are to deal with the combined problems of trauma and substance abuse. Yet in certain populations, including the chemically dependent and especially addicted women, the prevalence of significant trauma history and affects is so high that one could almost make the presumption it exists and then rule it out, rather than presume it is not present. Of course, trauma does not equate to PTSD, but there is clearly a relationship between Substance Abuse Disorders (SUD) and trauma, including PTSD. Among those diagnosed with PTSD, the coexistence of SUD is pervasive.

In a study of 5,338 veterans seeking treatment within the DVA specialized outpatient PTSD programs, 44% met criteria for alcohol abuse/dependence and 22% for drug abuse/dependence (MayoClinic.com, '08).

In certain studies, 60-80% of treatment -seeking Vietnam combat veterans with PTSD also met the criteria for current alcohol and/or drug abuse, and one study even found 91% of an inpatient sample meeting the lifetime criteria for substance use disorders (Meissler, A.W., '96). In a large survey of people from communities across the United States, it was found that 34.5% of men who had PTSD at some point in their lifetime also had a problem with drug abuse or dependence during their lifetime. Similar rates (26.9%) were found for women who had PTSD at some point in their lifetime. There were greater

Barry T. Hawkins, PhD

gender differences in the case of alcohol abuse or dependence, but prevalence was always high.

It may seem obvious that a causal relationship of some type exists, but there is no unanimity in regard to what that relationship is. Clearly there is a complex interplay between these disorders and their etiology. Some theories include:

Self Medication - This idea suggests that persons suffering from the symptoms of post traumatic stress will tend to use chemicals, either alcohol or other drugs, to ease those symptoms. An example would be use of the depressant alcohol, to decrease symptoms of increased arousal. Studies of Manhattan residents following the events of September 11, 2001 show significant increases in use of alcohol and other drugs. In some studies, PTSD has been associated with a fourfold increased risk of drug abuse and dependence (Chilcoat HD, Breslau N, '98). Several studies that looked at etiology found that trauma and/or PTSD tend to predate the onset of Substance Abuse Disorders, though some other research finds increased SUD more in PTSD than trauma alone (Lippincott, et.al., 2008).

Biochemical Shared Traits - This idea suggests that there are components of personality or biochemistry that are shared by those with symptoms of post traumatic stress disorder and substance use disorders. For instance, research into corticotrophin release factor suggests that this peptide triggers biological responses implicated in the patho-physiology of both disorders. Research suggests an overlap between neuro-circuits that respond to drugs and those that respond to stress (Piazza, P.V. '98). Going further, there is some research suggesting a genetic predisposition may come into play and influence these disorders. Mice that lack a receptor for CRF have impaired stress responses and express less anxiety-related behavior (Smith, et al,'98).

"In both people and animals, stress leads to an increase in the brain levels of…corticotrophin releasing factor (CRF). The increased CRF levels in turn triggers a cascade of biological responses.… Research has implicated this cascade in the pathophysiology of both substance use disorders and Posttraumatic Stress Disorder (PTSD)" (Jacobsen, 2001).

Developed Vulnerability - Persons subjected to prolonged stress or demonstrating symptoms of PTSD have poorly regulated hormonal responses that do not return to normal when the stress is past. Some theorists posit that abuse of drugs and alcohol not only put some persons at a higher risk of experiencing traumatic situations, but also reduces their ability to develop healthy coping mechanisms when those situations occur. Patients with substance abuse disorders tend to suffer from more severe PTSD symptoms than those without SUDs (NIDA, '02, '06) and substance abusers with PTSD experience higher levels of subjective distress and other problems than substance abusers without PTSD (Ouimette et al., 1996).

What Are the Treatment Options?

There is evidence of successful treatment effects for both medication and behavioral therapy. Certain anti-anxiety (e.g. buspar) and antidepressant drugs (e.g. sertraline) have shown themselves to be useful in ameliorating symptoms, though primarily as an adjunct to behavioral treatment.

Although there are some limitations to its use, Cognitive Behavioral Therapy shows general effectiveness. There may be contraindications for use in some severe states, but using the techniques and tools of CBT within a more inclusive treatment strategy seems benign, and indeed helpful in many cases. There is some evidence supporting exposure therapy when knowledgeable screening identifies appropriate subjects, though the research was primarily with cocaine abusers.

A specific treatment model for Chemical Dependency and Trauma "Seeking Safety", a 25 session course of treatment developed by Lisa Najavits', PhD, which includes a patient workbook. This model has shown successful outcomes and has the advantage of being able to be incorporated as an element within traditional CD treatment programs.

"Transcend" is a model developed by Donovan, Padin-Rivera, and Kowaliw primarily for combat related SUD and PTSD. That has two phases, the first of which includes partial hospitalization.

Dr. Elisa Triffleman has developed an intervention with more general application that consists of a two-stage intensive format, where the client meets with the clinician twice weekly for five months.

Isn't it risky to deal with two such potent problems at once? Historically, substance abuse treatment agencies had a "hands-off" policy on dealing with past trauma. As the conversation I described earlier demonstrates, this is a common belief in the CD Treatment community. The folk culture of recovery seems to support delaying the work of deeper issues until there is a solid base of recovery, and this idea was easily adopted by a treatment community that had few resources to tackle more pervasive issues in the short time allotted to SUD treatment. In truth, one of the challenges of treatment is that abstinence often results in increased PTSD symptoms and treatment of PTSD may result in increased use of substances as a coping device for the consequent emotional reactions generated as a part of the treatment. It is not surprising that the belief about separate treatment has become institutionalized.

"One patient who I talked to said that she had to lie to be able to get adequate treatment for both disorders. She was told when she went to a PTSD treatment program that she couldn't have substance abuse or she wouldn't be able to get treatment–she had to be clean first. And it's a message a lot of people have heard" (Lisa Najavits, PhD).

see Substance Use on page 13

Three Prominent Leaders Join MHNE Board of Directors

Staff Writer
Mental Health News

The Board of Directors of Mental Health News Education, Inc. (MHNE) has just announced the election of Constance Y. Brown, Dr. Jorge J. Petit, and Alison Tepper Singer to the Board. In making the announcement, Dr. Peter C. Campanelli, Chairman of the MHNE Board stated, "We are extremely honored and fortunate to be adding three very prominent leaders of the mental health, Latino mental health and the autism community to our board. The knowledge and expertise they will bring from their respective fields will greatly enhance our mission of providing vital evidence-based education to the community."

Constance Y. Brown, MPA

Jorge J. Petit, MD

Alison Tepper Singer

Constance Y. Brown, MPA, is the Vice President of Corporate Community Relations at the Institute for Community Living, Inc. (ICL) in New York City. In this capacity, Ms. Brown is responsible for overseeing and coordinating all community relations, marketing and advocacy activities aimed at reducing stigma and assisting consumers in their efforts to integrate seamlessly back into communities of their choosing. ICL was founded in 1986 with the opening of its first 150-bed residential program in downtown Brooklyn. This program served adults with serious and persistent mental illness. Since its inception, ICL has been committed to providing high quality services and supports to the people it serves permitting them to achieve their full potential while living in the community of their choice. In furtherance of that mission, ICL has developed a comprehensive array of support and treatment services for citizens with both mental illness and developmental disabilities. ICL now serves over 8,000 people per year throughout Brooklyn, the Bronx, Manhattan, Queens and Montgomery County, Pennsylvania. Prior to coming to ICL in 2006, Ms. Brown served as Public Health Partnership Coordinator at the Hudson Regional Health Commission (HRHC) in Hudson County New Jersey, as an Environmental Health Policy Analyst in Washington DC, as a Special Assistant to the District of Columbia Department of Health (DOH). Office of Environmental Health Science and Regulation, and as a member of the inaugural class of Capitol City Fellows tasked with putting her newly gained theoretical knowledge into practice through the completion of four six month rotations throughout various DC government agencies. She received her Master's in Public Administration with Honors specializing in Public Policy from Howard University, and Graduated *Cum Laude* from Norfolk State University where she earned her Bachelor's Degree in Political Science.

Jorge J. Petit, MD, is President of Dr. J. Petit Psychiatry Consulting. The firm provides consulting services for behavioral health systems including community -based behavioral health agencies, hospital psychiatry/behavioral health departments, and local and state regulatory entities. Dr. Petit is currently serving as Director of Innovations and Accountability for the NYC Health and Hospital Corporation (HHC), Kings County Hospital Center, with a primary focus on patient care and systems improvement. He is also working with the New York State Office of Mental Health (SOMH) and several other current projects with community-based clients. Prior to starting the firm, Dr. Petit was former Associate Commissioner for the Division of Mental Hygiene (DMH) at the New York City Department of Health and Mental Hygiene (DOHMH); a former Member of the Mayor's 9/11 Medical Work Group, and an advisor to the NYC Human Services Council's Mental Health Disaster Preparedness Committee; Co-Director of the Mount Sinai Medical Center's Department of Psychiatry; a bilingual and bicultural leader in bridging the gap of disparities for Latinos in the U.S; a member of the Geriatric Mental Health Alliance Latino Task Force of New York; and the author of "Handbook of Emergency Psychiatry" and "The Seven Beliefs: A Step-by-Step Guide to Help Latinas Recognize and Overcome Depression." He received his MD from the University of Buenos Aires, completed his internship and adult psychiatry residency at Mount Sinai Medical Center's Department of Psychiatry, and his Public Psychiatry Fellowship at Columbia University's Psychiatric Institute.

Alison Tepper Singer is Executive Vice President for Autism Speaks. Singer has been with the foundation since its launch in 2005 and is a staff member of the Board of Directors . Currently, she supervises all of the foundation's autism awareness initiatives, including its award-winning public service campaign, produced in conjunction with the Ad Council and the Centers for Disease Control (CDC). She is also the Executive in Charge of Production of Autism Speaks' documentary "Autism Every Day" which premiered at the Sundance Film Festival in 2007 and is used in schools across the country as a tool to teach educators about autism spectrum disorder. In addition, she oversees all of Autism Speaks' media relations activities and serves as a spokesperson for the organization, appearing on *Oprah*, *The Apprentice*, *NBC Nightly News*, *Good Morning America*, *CBS Early Show* and many other news programs. Singer also played a critical role in the passage of the Combating Autism Act of 2006, which authorizes the doubling of current federal funding for autism research. In 2007, Singer was appointed by Health and Human Services Secretary Michael Leavitt to serve as one of six public members of the Federal Interagency Autism Coordinating Committee (IACC). She also serves on the National Institute of Mental Health's *Alliance for Research Progress*. In past years she served on the IACC subcommittee for *Autism Research Matrix review* and on the Institute of Medicine planning committee for the *Autism and the Environment* conference. For the past four years Singer has served as the co-chair of the Westchester/Fairfield "Walk for Autism Research", and as co-captain of Team Scarsdale CHILD, the highest fundraising team in the nation. Singer also currently serves on the Executive Board of the Yale Child Study Center Associates Committee and the Westchester County Autism Council. From 2003-2006 she served as Co-Chair of Scarsdale CHILD (Children Having Individual Learning Differences) in Scarsdale, New York. Prior to joining Autism Speaks, Alison spent 14 years at NBC and CNBC, in a variety of positions including Vice President of Programming in NBC's Cable and Business Development division, where her many projects, she produced the award-winning CNBC series *Autism: Paying the Price*. She graduated magna cum laude from Yale University with a B.A. in Economics and has an MBA from Harvard Business School. Alison brings unequivocal leadership, vision and creativity to the senior management of Autism Speaks. As the mother of a child with autism and legal guardian of her adult brother with autism, she is a natural advocate.

Substance Use from page 12

However, there is general consensus among researchers and experts that PTSD and SUD should be treated simultaneously, with as much integration as possible given the current state of regulations and separate systems. This understanding needs to inform new models. Cross-silo collaboration between mental health and addiction systems is needed. As in the case of other co-occurring psychiatric and substance abuse disorders, integrative treatment is preferred. Thus, intensive treatment modalities such as partial hospitalization or intensive day treatment programs may be incorporated into the course of treatment, especially when used in early phases of treatment to improve outcomes. Intensive case management may also prove to be a key to better results.

Clearly, understanding and development of treatment options for co-occurring PTSD and SUD are in the early stages. One welcome change is the increased understanding that people undergoing chemical dependency treatment are also ready and able to address issues of trauma. They too, need to tell their story. "Patients in treatment for substance abuse want to talk about their traumas. It is no longer a question of whether to treat PTSD in substance abusers, but how to do it best" (Elisa Triffleman, MD).

Dr. Barry Hawkins, PhD, LMHC, CASAC, CATSM, is Director of Chemical Dependency Services for the Orange County Department of Mental Health. He is also Coordinator of the Orange County Mental Health Team for Disaster and Community Response, is Board Certified in Acute Traumatic Stress Management and is a Diplomate of the National Center for Crisis Management.

Mental Health Treatment in Westchester

The VNSW Mental Health Home Care Program provides:

- **Adjunct service to community mental health programs**
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- Liaison with the community treatment team informing them of changes and important symptoms that may indicate decompensation or need for changes in the treatment plan.
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- Coordinated home care services for non-compliant individuals and those with complex combined mental health/physical needs that present ongoing problems.

Program Features

- Facilitate psychiatric care from in-patient to home & community
- Prevent in-patient psychiatric hospitalization
- Decrease symptoms & improving functional ability
- Improve knowledge base about medications, illness, coping & staying well
- Improve medication compliance
- Access community services

The Big Picture

Visiting Nurse Services in Westchester (VNSW) believes in a holistic, broad approach to the treatment of mental illness, addressing the "whole person's" life circumstances and environment. VNSW fields nurses with advanced psychiatric training, and in some cases, advanced degrees in related fields. The staff provides home visits for assessment, evaluation and development of a treatment plan with interventions related to mental health issues in conjunction with medical/surgical needs. This program meets the total health care requirements of individuals utilizing a case management approach led by a psychiatric nurse specialist. Adjunct services complementing the mental health component include psychiatric social workers, home health aides, medical/surgical nurses and relevant rehabilitation therapies.

The program serves the elderly, adults, adolescents and children.

To receive further information or make a patient referral, contact:

Lisa Sioufas, LCSW-R, ACSW • Mental Health Program Manager
(914) 682-1480, Extension 648 • e-mail: MentalHealth@vns.org

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The PTSD Patient: Visiting Nurse Services in Westchester Treats the "Whole Person"

Staff Writer
Mental Health News

Over the past few years, there has developed a deeper understanding of the interrelationship between physical and mental health. Mental health problems are real, affecting one's thoughts, body, feelings and behavior. These feelings and behaviors are not just a passing phase and can be sufficiently severe to seriously interfere with the conduct of a sufferer's life. And nowhere does this more apply than with posttraumatic stress disorder, or PTSD. Commonly most associated_these days with the effects on adults of war and terrorist events, PTSD can in fact occur in persons of all ages, including childhood, for a variety of reasons; it is an anxiety disorder that can occur after a person has been through *any* traumatic event, grandiose or personal.

According to the DSM-IV-TR, the essential feature of PTSD is the development of certain symptoms following an extremely stressful event involving direct personal experience that involves actual or threatened death or serious injury, a threat to one's physical integrity, witnessing an event that involves death/ injury, a threat to the physical integrity of another person, or learning about the unexpected or violent death, serious harm, threat or injury to another close associate. The person's response to the event involves intense fear, helplessness or horror.

There are four types of symptoms related to PTSD: Reliving the event, Avoidance; Numbing, and Increased arousal. Such symptoms may occur immediately following the event, as a delayed experience, or intermittently over several years. Symptoms can be terrifying, disrupt individuals' lives and impede their ability to function in their daily activities. In patients with PTSD, the body's failure to return to its pretraumatic state differentiates posttraumatic stress disorder from a simple fear response. Symptoms must occur for a period of more than one month to qualify for a diagnosis of PTSD; symptoms occurring for less than three months are diagnosed as acute PTSD and for longer than three months as chronic PTSD.

Estimated rates of the prevalence of posttraumatic stress disorder in the community range between 7% and 12% (Yager, 2007). Approximately 25 to 30 percent of victims of significant trauma develop PTSD (Grinage, 2003). PTSD has been associated with high use of medical services. The condition is associated with significantly higher odds of having asthma, chronic obstructive pulmonary disease, chronic fatigue syndrome, arthritis, fibromyalgia, migraine headaches and other respiratory, cardiovascular, gastrointestinal or pain disorders (Yager, 2007). Individuals with PTSD have higher risks for mood and anxiety disorders, alcohol and drug dependence, and suicide attempts (Yager, 2007). Approximately 80% of patients with PTSD have at least one comorbid psychiatric disorder, with the most common disorders including depression, alcohol and drug abuse and other anxiety disorders (Grange, 2003).

According to the National Cancer Institute, people with histories of cancer are considered to be at risk for posttraumatic stress disorder. The physical and mental shock of having a life-threatening disease, of receiving treatment for cancer, and for living with repeated threats to one's body and life are traumatic experiences for many cancer patients. For the person who has experienced a diagnosis of cancer, the specific trauma that triggers PTSD is unclear. Cancer is an experience of repeated traumas and undetermined length. The patient may experience stress symptoms anytime from diagnosis through completion of treatment and cancer recurrence. Because avoiding places and persons associated with cancer is part of PTSD, the syndrome may prevent the patient from seeking medical treatment. It is important that cancer survivors receive information about possible psychological effects of their cancer experience and early treatment of PTSD symptoms (NCI, 2007).

Treatment options include patient education, social support and anxiety management through psychotherapy and psychopharmacological intervention. It is important for the therapist to focus on problem solving, teaching coping skills and providing a supportive setting for the patient. Cognitive behavior therapy is an effective approach used in the treatment of posttraumatic stress disorder. Some patients are helped by methods that teach the patient to change their behaviors by changing their thinking patterns. Relation techniques or other stress management skills, understanding symptoms, desensitization of upsetting triggers and redirection of negative thoughts can be very helpful techniques for some patients with PTSD. Support groups may help de-stigmatize the mental health diagnosis and provide patients with emotional support by introducing them to other people with similar experiences and symptoms. A physician may prescribe medications, including antidepressants, anti-anxiety medications and antipsychotic drugs.

The mental health program at the Visiting Nurse Services in Westchester (VNSW) has and continues to service many patients with posttraumatic stress disorder. The agency works with providers in the community to help patients recover from PTSD by helping them manage, monitor and pre-fill medications. If needed, VNSW is able to utilize locked medication boxes to ensure compliance and safety, and the agency's mental health nurses monitor patient mood and symptoms. The VNSW nurses provide patient education and employ a variety of the techniques used to treat PTSD and work collaboratively with the patient's providers to ensure continuity of care.

After many years of experience in treating patients with posttraumatic stress disorder, VNSW believes strongly in taking into account the entirety of a patient's health status. Since PTSD patients often exhibit comorbid psychiatric and medical conditions, VNSW integrates into their treatment many specialized nursing services that target indicated medical and psychiatric needs. The agency's nursing specialties include pain management, palliative care, cardiac care, wound care, mental health and diabetic management including a certified diabetic specialist who is also a mental health nurse. In addition to nursing care, VNSW provides a full range of rehabilitative therapies, social work and home health aide services; PTSD patients receive comprehensive care from a coordinated team of health care professionals versed in, and sensitive to, their complete history and needs, providing a complete package of essential multidisciplinary services to help them attain and *maintain* optimal health and functioning.

With its dedicated Mental Health Home Care Program, Visiting Nurse Services in Westchester is working actively toward this objective, emphasizing treatment of the whole person with the agency's core multidisciplinary approach. For details, visit www.vns.org, call (914) 682-1480 Ext. 648 or e-mail MentalHealth@vns.org.

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The Mental Health News
Nassau County Section

Promoting the Health and Well-Being of Veterans and Their Families

By John A. Javis, MDiv
Director of Special Projects,
Mental Health Association of Nassau County

Even though the U.S. has been at war in Afghanistan since 2001 and in Iraq since 2003, it wasn't until the summer of 2006 that the first reports of unusually high levels of Post Traumatic Stress Disorder (PTSD) among returning veterans were highlighted by the media. In the winter of 2007, the media reporting on the Walter Reed and the VA scandals began calling national attention to the plight of veterans traumatized by war. What followed was a flurry of statistics and studies relating to veterans behavioral health issues.

Nationally, of the veterans of Iraq and Afghanistan that were treated by the VA: 38% had a mental health concern, 17% had a substance abuse issue, and11% suffered a Traumatic Brain Injury.

Recent media reports indicate that 18 veterans a day nationwide commit suicide; and the national Veterans Suicide Prevention Hotline, based in Canandaigua, NY fields between 130 – 140 calls per day.

John A. Javis, MDiv

Someone that I looked up to when I was in the military, Colonel Ted Westhusing, lost his life to suicide. Colonel Westhusing had graduated 3rd in his class at West Point, where he was the Honor Captain. The Honor Captain is in charge of the cadet honor code that says that, "A cadet will not lie, cheat or steal, nor tolerate those who do." He was Airborne and Ranger qualified. He was a man of deep faith.

In the summer of 2005, I was driving home from work when I heard on the car radio that Colonel Westhusing died in Iraq of "non-combat related causes." While I was sad, my assumption was that he might have died during a vehicle accident or from an illness. I was stunned to read a media report in the spring of 2007 that his death was by suicide. The report indicated that Colonel Westhusing had been placed in charge of security in Iraq, where he uncovered scandal among both American civilian contractors and Iraqi security forces.

His wife reported that his e-mails home became depressed, as he couldn't justify in his mind the values he learned at West Point, with what he saw going around him. Fellow officers indicated that he became obsessed with his pistol; he ultimately took his life with that pistol, after writing a suicide note. He only had about a month left to go in Iraq.

In the wake of this nationwide crisis involving the care of veterans, the Veterans Health Alliance of Long Island was formed in November of 2007.

The Veterans Health Alliance of Long Island, a project of the Mental Health Association of Nassau County, is a collaborative effort of over 60 mental health and substance abuse providers, county and state mental health and substance abuse oversight bodies, the VA, county Veteran Service Agencies, VET Centers, veterans organizations, elected officials, and local universities. The mission of the Alliance is to: "Promote the health and well-being of Long Island veterans and their families through advocacy and a broad array of services."

Veterans issues are critical on Long Island. Of the 1,000,000 veterans who live in New York State, over 174,000 live on Long Island. In fact, Long Island is second only to San Diego in the percentage of veterans among its citizens.

The Veterans Health Alliance of Long Island supports veterans and their families through three workgroups.

Outreach: Veterans who returned from Iraq and Afghanistan in the earlier

see Veterans on page 37

From Da Nang to Baghdad: Treating Combat PTSD

By Denis Demers, PhD, LMSW
Director, Mental Health Outpatient Services
Catholic Charities of the
Diocese of Rockville Centre

In 1971 I was assigned to the 98th Medical Detachment, KO Team, one of two specialized, 28 man units made up of psychiatrists, a social work officer, nurses, and paraprofessional enlisted specialists in social work and neuropsychiatric procedures to assess and treat psychiatric casualties and drug and alcohol abuse in the combat theater that comprised the then Republic of South Viet Nam.

Our mission was to "Conserve the Fighting Strength." This meant we were not only to treat psychiatric and chemical dependence problems but to sort out those trying desperately to get out of their combat unit, from individuals who were truly psychotic and could not function safely in a combat situation. The diagnosis of Post Traumatic Stress Disorder (PTSD) did not exist at that time. Rather, the official military diagnosis was "combat stress," the latest name for what had been known in World War II and Korea as "combat fatigue" and in World War I as "shell shock."

The course of treatment for combat stress included rest, supportive counseling, visitations from members of the soldier's unit, and return to duty within 30 days. To do otherwise, we were told, was to risk the soldier's emotional well-being by allowing an "easy" way out of an unpleasant and often terrifying situation, and possibly result in serious regrets, such as survivor's guilt if his buddies were later killed or wounded. In truth, as we now know, stress reaction to emotional trauma is cumulative if not resolved before being re-traumatized by later events. We were undoubtedly returning soldiers to their units who were still suffering symptoms of emotional trauma.

Subsequent research involving Viet Nam vets led to recognition by the APA of the formal diagnosis of Post Traumatic Stress Disorder in the Diagnostic and Statistical Manual. The Veterans Administration went on to develop or adopt treatment modalities and techniques that now include desensitization, flooding, cognitive behavioral therapy, and EMDR, to name a few. Military psychiatry also evolved as evidence-based practices are continually introduced and research conducted involving military behavioral health professionals and paraprofessionals in implementing what is now termed Combat Operational Stress Control (COSC) measures.

Emphasis is also placed on preventive measures in what is termed "Battlemind" readiness. Battlemind is a descriptive term used to prepare soldiers, in training, on what emotional stressors they can expect to experience and how to prepare themselves for coping with it. It also addresses the need to develop a certain mental toughness and adaptive behaviors to functioning safely in a combat zone. Officers and non-commissioned officers are trained to recognize and minimize the impact of stress on their subordinates. Nevertheless, in this era of an all volunteer military, with a smaller number of men and women in arms, repeat deployments has accelerated the consequences of additional traumatic experiences on our military. And its impact extends beyond the individual soldier to his family and other natural support networks who must live with traumatized soldiers as they struggle to readjust to civilian life.

Battlemind behaviors are often difficult to put aside when returning from war. They become maladaptive behaviors outside a combat zone. If compounded by untreated combat stress, these behaviors can become destructive to the soldier and to those close to him or her.

Military psychiatry still struggles with the same issues as civilian psychiatry, including stigma and inadequate levels of service availability. Soldiers, returning from a combat tour are eager to get home and will not fully disclose signs and symptoms of traumatic stress. This can be exacerbated in an all volunteer military since many soldiers are reluctant to disclose their emotional struggles for fear of jeopardizing their careers or experiencing derision at the hands of their fellow soldiers in a culture that prides itself on toughness. They are also more likely to shun treatment made available both by the active duty military and the Veterans Administration, for fear of disclosure. Additionally, these systems must contend with increasing numbers of veterans as the

see Combat on page 37

Helping Children Come to Terms with Sexual Abuse

By Mary Lou Jones, DSW, LCSW and Lisa Littman, LCSW South Shore Child Guidance Center

The classic definition of "trauma" provided by Bessel Vander Kolk (1987) includes both the dramatic nature of an event as well as the individual's ability to cope. Despite our capacity to survive and adapt, trauma can alter one's psychological, biological and social equilibrium to such a degree that this extreme event interferes with all other experiences including any appreciation of the present (Vander Kolk 1995).

Not all individuals who experience trauma suffer from Post Traumatic Stress Disorder (PTSD) however. The American Psychiatric Association (2000) notes that to assign a diagnosis of PTSD, an individual must exhibit one or more of the following: The traumatic event is persistently re-experienced (through recurrent thoughts, dreams and/or flashbacks); Persistent avoidance of stimuli associated with the trauma (through efforts to avoid thoughts, feelings, activities, places or people that might arouse recollections of the trauma); Persistent symptoms of increased arousal (such as sleep disturbance, difficulty concentrating, anger outbursts, hyper-vigilance, or exaggerated startle response).

Mary Lou Jones, DSW, LCSW

In addition, various factors affect the duration and severity of the trauma response including: severity of the stressor, developmental level, genetic predisposition, social support system, prior traumatizations, and re-existing personality.

For children who have experienced a form of trauma, (e.g. sexual abuse) the trauma disrupts and sometimes destroys the sense of an "intact self" (Garfield & Leveroni 2000); the child's sense of self lacks the esteem for regularity psychic structure (Stolorow & Lackmann 1980).

Sexual abuse continues to emerge as a major form of child abuse in our society today. Childhood sexual abuse may be defined as contacts or interaction between a child and an adult when the child is being used as an object of gratification for the adult's sexual needs (de Vine 1980). Sexual abuse of children by an adult is victimization that occurs within the power differential of a relationship between perpetrator and victim. When this contact happens within the family system (e.g., father, mother, brother, sister, cousin, stepfather), it is defined as incest. Childhood sexual abuse also often happens outside the family system, e.g., close neighbor, teacher, babysitting) and involves similar dynamics, such as denial, repetitiveness, betrayal and trauma (Jones 1996).

Events which traumatize are not only a violation of the child; they also result in a violation of his or her basic sense of how the world works. The trauma destroys self concept as well as the child's assumptions of others and the environment. (Janoff-Bulman 1992; Pearlman & Soskvitne 1995).

Fortunately, treatment exists and often works for many of these children! During therapy, survivors of sexual abuse trauma are encouraged to come to terms with what happened in the past, as they learn to develop effective and more successful coping strategies (Knight 2006). Primarily, the therapeutic relationship is both a means through which recovery and healing occurs and is a significant component of the healing process.

Trauma Based Cognitive Behavioral Therapy (CBT) has been proven effective in working with children who are suffering from Post traumatic Stress Disorder due to sexual abuse (Cohen,J. A., & Mannarino, A. P. 1998). Furthermore, Trauma Based CBT has been designated a model program by the National Registry of Evidence Based Programs and Practices and the Substance Abuse and Mental Health Service Administration (SAMSHA). Research has also indicated that Trauma Based CBT is effective in working with children who are suffering from multiple traumas, as well as depression, and behavioral problems (Cohen, Judith A., Anthony P. Mannarino, Lucy Berliner, and Esther Deblinger 2000). Although Trauma Focused CBT is structured and implemented in a series of segments, it is adaptable to meet the individual needs of the client. As noted above, the most important factor to any type of treatment is to create a positive therapeutic alliance with the client. (Krupnick, SM Sotsky, I Elkin, S Simmens, J .Focus, 2006). Trauma focused CBT

see Sexual Abuse on page 38

Principles of Group Work with Children and Youth Trauma Survivors

By Andrew Malekoff, LCSW, CASAC Executive Director and CEO, North Shore Child and Family Guidance Center

Group work is indispensable for children and youth in the aftermath of traumatic events. Group work can serve as a counterforce to bleak outcomes that result from isolation in the aftermath of disaster. It can help to empower young people by restoring human dignity, building coping skills, helping them to find their voice, and making things happen on personal, interpersonal, and social/community levels.

If "trauma isolates," as Judith Herman says; group work connects. Following are practice principles for group work to help children and youth to heal and feel empowered in the aftermath of disaster by building individual coping skills and preventing isolation.

Principle 1 - Provide protection, support, and safety. Children and youth need safe places to go, with worthwhile things to do, and opportunities for belonging. And they need relationships with competent adults who understand and care about them. Living through traumatic events can contribute to a pervasive sense of fearfulness, hyper vigilance and despair. Participation in a safe and supportive group can serve as a counterforce to the alienating and numbing aftermath of a traumatic event.

Group workers must carefully attend to the structure of the group to ensure a basic level of physical and emotional safety that helps to cultivate a sense of trust. This requires both hands on practice savvy and ongoing advocacy to ensure sound environments for group development. A safe haven is a prerequisite for tapping in to what one has to offer post-trauma.

Andrew Malekoff, LCSW, CASAC

Principle 2 - Create groups for survivors that re-establish connections and rebuild a sense of community. According to Erik Erikson, collective trauma is "a blow to tissues of social life that damages the bonds linking people together, and impairs the prevailing sense of communality." Trauma leads to demoralization, disorientation, and loss of connection. In the aftermath of trauma individuals feel unprotected and on their own, as orphans who feel they must take care themselves.

Participation in a supportive group addresses the primary need of trauma survivors to affiliate. Group affiliation can provide mutual support, reduce isolation, and normalize young (and older) peoples' responses and reactions to what feels like a surreal situation. When addressed in a group context, these are important steps to rebuilding a sense of community.

Principle 3 - Offer opportunities for action that represents triumph over the demoralization of helplessness and despair. "Talking about the trauma is rarely if ever enough," advises noted trauma expert Bessel van der Kolk. He points to the Holocaust Memorial in Jerusalem and the Vietnam War Memorial in Washington D.C., "as good examples of symbols that enable survivors to mourn the dead and establish the historical and cultural meaning of the traumatic events…to remind survivors of the ongoing potential for communality and sharing."

Van der Kolk goes on to say that this also applies "to survivors of other types of traumas, who may have to build less visible memorials and common symbols to help them mourn and express their shame about their own vulnerability." Examples are writing books or poetry, engaging in social action, volunteering to help other victims, or any of the multitudes of creative solutions that individuals can find to confront even, as he puts it, "the most desperate plight."

Competent group work requires the use of verbal and non-verbal activities. Group work practitioners must, for once and for all, learn to relax and to abandon the strange and bizarre belief that the only successful group is one that consists of people who sit still and speak politely and insightfully.

Principle 4 - Understand that traumatic grief is a two-sided coin that includes both welcome remembrances and unwelcome reminders. Group work can provide a safe space for young people to grieve their lost loved ones in the aftermath of a disaster. However, there are dimensions of remembering that can be crushing absent the tools to cope, when one is traumatically bereaved.

The two sides of the "remembering coin" are: welcome remembrances of a lost loved one and unwelcome reminders of a loved one who was lost. One side is empowering and involves addressing sadness and longing, by gradually welcoming loving memories. The other side is disempowering and involves intermittently succumbing to uninvited and intrusive thoughts and the tyranny of imagination.

Conclusion: These principles emphasize the value of group affiliation as an

see Group Work on page 38

The Mental Health News
New York City Section

Trauma, Stress and the Financial Crisis: Impact and Intervention

By Steven M. Crimando, MA, BCETS, CTS
Managing Director, ALLSector Technology Group, a Subsidiary of the F.E.G.S. Health and Human Services System

Is a financial crisis traumatic? In her writing and teaching, noted grief and loss researcher Katherine Shear, MD has defined grief as something good leaving our lives and trauma as something bad coming into our lives. The current crisis has elements of both grief and trauma, especially for those in and around New York City whose livelihoods directly or indirectly are dependent on the financial industry. Like other disasters, a sudden financial crisis can result in loss, anxiety and uncertainty about the future. Much of what is known about the emotional and behavioral response to other types of disasters can be helpful in managing the psychological consequences of the financial crisis. Left unchecked, these consequences can further complicate individual, community and organizational recovery.

The Emotional Impact of the Economic Meltdown

In major disasters there are unfortunately many instances when individuals and families truly do lose everything. Losses can include loved ones, a home, pets, irreplaceable keepsakes and more, including a sense of community or safety. Deeply-held personal or religious beliefs can be shaken. In many situations and specifically in financial disasters, those loses can be somewhat imperceptible and not obvious to others. A financial crisis can result in a loss of identity and belonging, control, confidence, security, financial and otherwise, status and role, trust, future, purpose, and hope.

Across different types of disasters and crisis events, it is common for those individuals directly affected, as well as those in their immediate circles, to experience a range of reactions. And while these are natural and normal responses, they can certainly be unpleasant and add to one's overall discomfort. Such reactions include physical, emotional, cognitive and behavioral changes that in some instances can complicate the situation and become barriers to coping with the challenges ahead. While these reactions are widely seen in response to natural and technological disasters, they are common in other interpersonal crises where there is an element of threat. Threat to one's survival due to a financial crisis is no different. Most of these reactions are short-lived and self-resolved as the individual moves along the timeline of the event. For some, these reactions can be more pronounced and prolonged. There may even be instances in which, in a more extreme form, one or more of these reactions may represent the symptoms of a medical or psychological emergency.

Physical Reactions - Shock-like reactions, insomnia, loss of appetite, headaches, fatigue, and elevated blood pressure and heart rate.

Emotional Reactions - Depression and anxiety, numbness, constricted range of emotions, guilt, shame, and doubt, intolerance of emotional response, pessimism, and hopelessness.

Cognitive Reactions - Distractibility, memory problems, decreased problem-solving ability, declining work performance, recurrent intrusive thoughts, and nightmares.

Behavioral Reactions - Thrill-seeking, risk-taking, preoccupation with related news stories, rumors, etc., increased substance abuse, jumpiness, and feeling "wired."

Interpersonal Reactions - Clinging, isolating, irritability, argumentative, distant, detached, increased/decreased need for physical intimacy, and wanting to be only with co -workers/avoiding contact with co-workers.

Chest pains, arrhythmias or heart palpitations, as well as respiratory distress and acute abdominal pains may be the signs of something more serious and require medical attention. While potentially stress-related, these reactions should not be dismissed. Likewise, suicidal and/or homicidal thinking, as well as serious mental disorganization or disorientation may be the signs of psychological emergencies and should be assessed by medical or mental health professionals.

During a time of increased personal and professional demand, the impact of sleep problems, poor concentration, depression, apathy and increased use of alcohol and other substances can become serious obstacles to problem-solving and decision-making. Problems in personal relationships can create tension and distance from those who might be most helpful and supportive. The emotional consequences can be significant and difficult to address if not taken seriously and proactively.

Managing the emotional and behavioral consequences of any disaster, natural, technological or economic, is critical to the recovery of the individual and their family, as well as the community and organization. The psychological impact of the current financial crisis should not be ignored or minimized. For many people this crisis represents substantial losses and a threat to personal and professional survival. This should not be underestimated in any way.

Coping with Surging Stress Levels

There are coping strategies and techniques that can be helpful for individuals and families, as well as organizations. Many of these are similar to those being used today to assist the survivors of other disasters across the country and around the world.

Here are some useful suggestions for coping with the stress and anxiety stemming from the financial crisis: limit exposure to news stories and constant alerts about the stock market and economic climate; get accurate, timely information from credible sources (avoid rumors if possible); try to maintain a routine, even if you must create a new one; exercise, eat well and rest, even though it may be difficult to sleep; stay busy both physically and mentally; communicate with friends, family and supporters and let people know how they can help; use spirituality and your personal beliefs; keep a sense of humor; take one day at a time.

The great risk communications expert, Peter Sandman, PhD, advises that, "Action binds anxiety." Doing something is almost always more psychologically helpful than doing nothing. Individuals and organizations would do well to heed Dr. Sandman's advice. Getting people active in support groups and social networks, as well as practical hands-on activities is important. It is known that people who actively participate in rescue and recovery tasks during disasters fare much better, physically and mentally, than those who withdraw, become passive or apathetic. Keeping busy, focused and productive during stressful times is essential to counteracting feelings of helpless and fear.

No One is Untouched

Deborah DeWolfe, PhD, author of one of the first field guides developed for disaster mental health response stated, "No one who experiences a disaster is untouched by the event." This is not to say that everyone is traumatized or psychologically damaged in some way, but a sudden, shocking and threatening event takes its toll. It is estimated that almost 9,000 employees lost their jobs in the Bear Stearns restructuring. Ultimately, job losses may be in the tens of thousands across the financial industry and countless more in service jobs that rely on financial sector workers as customers in the restaurants, bars and boutiques in and around the financial districts. A storm, earthquake or act of mass violence resulting in tens of thousands of lost jobs would certainly be called a disaster. Make no mistake, the life-changing events of the past several weeks in the global financial system are also a disaster and no one is left untouched.

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Challenges in the Assessment of Trauma Among Individuals with Disabilities

By Oren Shtayermman, PhD, MSW
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Oren Shtayermman, PhD, MSW

Data from the field of disabilities suggests that individuals diagnosed with disabilities may be at higher risk for being exposed to and experiencing events that could precipitate the development of trauma symptoms when compared to their nondisabled counterparts (Strauser, Lustig & Uruk, 2007). On an average, individuals diagnosed with a disability have between 4 to 10 times more chances of becoming a victim from interpersonal violence than a person without a disability (Focht-New, Barol, Clements & Milliken, 2008). According to the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 1994), a traumatic event is defined as an occurrence in which both of the following were present: first, the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, and second, there was a threat to the physical integrity of self or others. McCarthy (2001) stated that it is well recognized that a traumatic event can cause psychological disorders in those who experience them. Because of the augmented probability that individuals diagnosed with disability may experience violence, it is recommended that mental health professionals be educated about the symptoms associated with trauma (Strauser, Lustig & Uruk, 2006).

Anxiety Disorders, Trauma, and Emotional Memory: According to the National Institute of Mental Health (2008), anxiety disorders are the leading forms of mental illness impacting the lives of more than 40 million Americans ages 18 years and older (18%). One of the anxiety disorders is post-traumatic stress disorder which can be found in more than 7.7 million American Adults. Sotgiu and Mormont (2008) argued that it is necessary to differentiate between traumatic events and emotional events. All traumatic events have an emotional component; however, not all emotional events may be classified as traumatic. Emotional events can be described as situations that are relevant to a person's well-being and could be either positive or negative. Examples of negative emotional events are arguing with a close friend, learning that a family member is ill, being verbally threatened or failing an exam. Cases such as birth of a child, romantic kiss, receiving a present or getting a job are considered to be positive events.

Challenges in Assessment: Personally experienced events, either traumatic or emotional, are encoded in mental representations that are stored in long term memory. Consequently, they may be subject to reconstructive processes that can influence the retrieval of originally coded information (Sotgiu & Mormont, 2008). A presentation of a particular anxiety disorder, trauma in particular, may be different among those individuals who are diagnosed with severe developmental delay or those who does not have the communication skills necessary to describe their thoughts, feelings and mood (McCarthy, 2001). An additional challenge that mental health professionals are faced with is the accuracy and ability to utilize the DSM-IV when assessing individuals diagnosed with disabilities. One of the criticisms regarding the DSM-IV as an assessment tool is related to the ability of the tool to assist mental health professionals with determining an appropriate diagnosis. The categories in the DSM-IV are not mutually exclusive or exhaustive. This could lead mental health professional to assign an incorrect diagnosis which will lead to an inappropriate focus of treatment. Since most mental health conditions do not occur in isolation and in many cases mental health disorders co occur, the assessment of trauma could be challenged.

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more about the clinical services offered, as well as our ongoing research projects, please visit our website: www.AboutOurKids.org.

Christie Jackson, PhD, is Clinical Assistant Professor, Kate R. Kuhlman, BA, is Project Associate, and Marylene Cloitre, PhD, is the Cathy and Stephen Graham Professor of Child and Adolescent Psychiatry at the Institute for Trauma and Resilience, NYU Child Study Center.

Responding to PTSD in Our Communities

By Paula G. Panzer, MD, Director and the Staff of the Trauma Center Jewish Board of Family and Children's Services (JBFCS)

Sitting: Christina Grosso, Paula Panzer, Susan Paula. Standing: Alice Psirakis, Caroline Peacock, Randi Anderson, Deborah Langosch and Linda Payne

We see the words Posttraumatic Stress Disorder (PTSD) everywhere -- on the front page of major newspapers, on the shelves of bookstores in the self-help section, on prime-time television, and on the floor of Congress. When you hear 'PTSD' what do you think? Veterans? September 11th? Hurricane Katrina? What about children who witness domestic violence or are removed from their homes due to parental death, disability or instability? How about bystanders to a drive-by shooting? We also call to mind rape survivors – children and adults. There are those who survive fires, motor vehicle accidents and floods, but are then ravaged by the memories of their experiences and have PTSD. Don't forget the first responders – to disasters, fires, and interpersonal violence. These workers, including social service and mental health providers, risk secondary exposure to trauma and their own PTSD. With violence, disrupted family bonds, forced displacement and natural disasters as part of our social fabric, we need to take a broad view of the potential PTSD sufferers in the communities we serve.

What is PTSD? Officially labeled in the DSM in 1980 (APA, 1980), PTSD occurs after a traumatic event triggers fear, helplessness or horror. Symptoms include re-experiencing (flashbacks, nightmares), avoidance and numbing, and hyperarousal. Sleep is usually disturbed. Somatic complaints often occur, and long-term health problems (KR Cromer & N Sachs-Ericsson, 2006) have been reported. The avoidance that comes with PTSD leads many individuals to avoid thinking or talking about their difficulties, so they do not often seek mental health care for this disorder.

Most trauma survivors do not develop PTSD. Many have stress reactions, such as reactivity, fear, and disrupted sleep. Most of these will resolve with time in the setting of good social, intrapersonal and coping skills and, on some occasions, with early interventions. Some survivors may develop depression after trauma exposure. Other adults go on to develop panic disorder, generalized anxiety, and substance abuse. Children show more disruptions in their relational and cognitive development, and specifically develop anxiety disorders, disorders of conduct, and exhibit somatic distress. So how do we help those in our communities who have PTSD? Fortunately, we know that good community care, evidence-informed treatments, expressive approaches, and thoughtful, alternative care can be used to alleviate trauma-related suffering.

Treatment begins with a careful assessment and psychoeducation. Information about PTSD helps to normalize symptoms and make clear the path to recovery. Explanations accompanied by some understanding of the biological nature of PTSD (as an overwhelming stress response) help diminish stigma and engage families in treatment. For combat veterans, early work focuses on recognizing the conflicting messages of the warrior mentality (suck it up and drive on) and the veteran's own instincts (I know that something is not right and I need help). For children and those involved in community violence, establishing physical safety is crucial. There is clear evidence that very young children's reactions to trauma are strongly affected by how well the people who take care of them cope with trauma. Clinicians are advised to do a thorough assessment of caregivers and attend to their wellbeing when working with traumatized infants and young children.

All evidence-informed trauma treatments include all or most of the following sequenced, critical components: psychoeducation about PTSD and the effects of trauma exposure; safety planning; goal setting; affect regulation skills; thought restructuring skills; social and communication skills; and exposure. During the

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The NYC Department of Health and Mental Hygiene Responds to Post 9/11 Public Need

By Trish Marsik and JoAnne Mclean NYC DOHMH

In recognition of the lasting psychological consequences of the WTC attack for many New York City residents, the NYC Department of Health & Mental Hygiene launched the NYC 9/11 Benefit Program for Mental Health and Substance Use Services. This benefit helps cover the costs of services specifically for people still experiencing psychological distress or struggling with substance use due to the events of September 2001. Outreach efforts are aimed at finding people who were affected either directly or indirectly by the WTC attacks, with particular emphasis on reaching people who haven't stepped forward to receive needed treatment.

While the program covers many different services for many different mental health problems, nearly a quarter of those who have filed claims have a diagnosis of PTSD (24%), indicating that individuals affected by 9/11 are still suffering from PTSD 7 years after the event and are in need of services. Further, over one third of the individuals who have initiated enrollment in the NYC 9/11 Benefit Program report they have not previously received treatment. This underscores the continuing need for mental health services among those affected by the WTC attacks, and for outreach activities aimed at reaching individuals who may not have previously stepped forward to receive treatment.

One key feature of the program is that participants are able to receive treatment from a practitioner of their own choice providing the individual is New York State licensed and is practicing in New York State. Choosing one's own practitioner also reduces barriers an individual may face in obtaining treatment due to geographic location of participating providers, or system-induced difficulties such as not being able to access timely or efficient care.

The NYC 9/11 Benefit Program is addressing the concern clinicians may have about treating individuals with PTSD by collaborating with clinicians from the WTC Centers of Excellence to develop a training protocol to be offered to mental health providers who are treating 9/11 victims. This training will encompass evidence-based treatments for PTSD, and provide ongoing support for clinicians who participate in the training.

PTSD is characterized by symptoms such as distressing memories, nightmares, or flashbacks, avoiding reminders of the traumatic event, feeling emotionally detached or numb, and insomnia or poor concentration. The estimated lifetime prevalence of PTSD among adult Americans is 7.8% (National Center for PTSD, 2006). Women (10.4%) are twice as likely as men (5%) to have PTSD at some point in their lives (National Center for PTSD, 2006), and higher rates of the disorder have been found to occur in African-Americans, Hispanics and Native Americans.

The effects of PTSD can be devastating. PTSD often leads to problems in familial and other interpersonal relationships, problems with employment, and involvement with the criminal justice system. Deykin (1999) reports that the onset of PTSD in adolescence has a particularly damaging impact since it may impair the acquisition of life skills needed for independence and self-sufficiency. Further, individuals with PTSD may be more likely to develop other mental health disorders such as depression and substance use.

People involved in rescue/recovery work following natural and manmade disasters are exposed to physical and emotional trauma, increasing their risk of PTSD (Perrin, DiGrande, Wheeler, Thorpe, Farfel & Brackbill, 2007). A study conducted of the rescue and recovery workers enrolled in the World Trade Center Health Registry reveals that 2-3 years after the attack the overall prevalence of PTSD among rescue and recovery workers was 12.4%, ranging from 6.2% for police to 21.2% for unaffiliated volunteers (Perrin et al, 2007). A new study released by the NYC Department of Health & Mental Hygiene's World Trade Center Registry reveals that one in eight (12.6%) lower Manhattan residents likely had PTSD two to three years after the attacks (World Trade Center Medical Working Group Annual Report on 9/11 Health, 2008). These studies indicate that a large proportion of individuals exposed to a traumatic event continue to suffer psychological consequences several months after exposure the event.

Unfortunately, only 7% of those with PTSD seek mental health care within the first year of onset, and the median time delay for seeking help is 12 years (Wang, Berglund, Olfson, Pincus, Wells & Kessler, 2005). Barriers to treatment vary among different people with PTSD. In a study of individuals with probable PTSD following the WTC attack, the primary reason individuals did not seek treatment was that they did not believe they had a

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to improve the services we offer to our New York Army and Air National Guard members returning from combat deployments. Our reintegration program is designed to ease the transition from full-time Soldier to civilian and we embrace any way to improve it. Since 9/11 more than 9000 Citizen Soldiers and Airmen have served in combat zones and we owe these men and women nothing less."

Michael F. Hogan, PhD, Commissioner of the New York State Office of Mental Health, said: "Our shared goal is to have accessible, competent and welcoming support throughout New York State for all veterans and their families who require our assistance. Our soldiers are currently involved in a conflict that produces unbelievable stresses because of multiple deployments and the close, violent and unpredictable nature of the conflict. It is becoming evident that behavioral health problems are among the leading health challenges of this war, as they are in society. But we owe a special debt to soldiers and their families to help when it's needed."

Commissioner Karen M. Carpenter-Palumbo, of the Office of Alcoholism and Substance Abuse Services, said: "With one million veterans in New York and increasing drug and alcohol use among veterans returning from Iraq and Afghanistan, this is a critical time for OASAS to respond with treatment and recovery services. We know that four out of 10 of the veterans in our system are struggling with a mental health disorder and that criminal

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the mental health association of new york city, inc.

The Aftermath of Trauma: How a Mental Health Community Responds

By Giselle Stolper
Executive Director
The Mental Health Association of New York City

Traumatic events are naturally stressful on our bodies and on our minds. Feelings of fear, helplessness, anxiety, and emotional distress are generally common in populations exposed to trauma and these symptoms can last for many months and even years. Whether natural disasters, such as Hurricane Katrina, or man-made disasters, such as September 11th, statistics show that about 10% of the US population will experience a disaster at some point in their lives. For many people, symptoms of stress subside within a few weeks. Some people, however, continue to experience a strong psychological response to trauma, months and years later. It is the responsibility of the mental health field to ensure that communities are educated and informed about mental health risks and to provide long-term mental health care and support.

In the aftermath of September 11, 2001, New Yorkers exposed to the attacks had to cope with the physical and emotional toll of these events. Post-Traumatic Stress Disorder (PTSD) is one of the most common long-term mental health conditions exhibited by those exposed to 9/11/01. According to the NYC World Trade Center Health Registry, an approximate 410,000 individuals experienced

Giselle Stolper

first hand exposure to the World Trade Center Disaster. Of these, an approximate 16% exhibited symptoms of PTSD two to three years after the attacks. Despite the high rates of PTSD that followed 9/11, rates were actually lower than those expected after the attacks. This may have been due to the coming together of the mental health community in New York City.

Following 9/11, non-profits throughout New York provided much needed resources and assistance to those affected. In collaboration with the American Red Cross and the September 11th Fund, the Mental Health Association of New York City (MHA of NYC) was instrumental in making mental health care affordable and accessible to those exposed to the World Trade Center attacks. Today, MHA of NYC continues to offer assistance to New York City residents that are still feeling emotional reactions to the events of 9/11/01. Together with the NYC Department of Health & Mental Hygiene, the MHA of NYC is administering the NYC 9/11 Benefit Program, which provides NYC residents with financial assistance for outpatient mental health and substance use services. The steady support provided by the MHA of NYC to 9/11 survivors is a model for the kind of support that should be included in disaster recovery plans.

After 9/11, the MHA of NYC continued to be of support to mental health communities nation-wide. In September of 2006, the MHA of NYC was once again called upon by the American Red Cross, this time to provide mental health benefit services to the Gulf Coast. The devastation of Hurricane Katrina did more than just change the physical landscape of the Gulf Coast; it changed the way of life for many people in the area. The MHA of NYC was able to respond to the mental health needs of this community by establishing a 24 hour call center that offered referrals to local services and also enrolled clients for mental health benefits offered by the Red Cross. More recently, the MHA of NYC assisted call centers in Texas following Hurricane Ike.

As natural disasters are inevitable and unpredictable, it is important for mental health communities to be prepared to manage the consequences that follow such events. Although communities that are directly impacted bear the bulk of stressors, trauma can also affect many communities indirectly. Following 9/11, the United States witnessed an overall increase in stress-related symptoms. Within a week of the September 11th attacks, 44% of US adults reported feeling "substantial" symptoms of stress.

Regardless of causative events, the lifetime prevalence rate for PTSD in the United States is 8%. For many individuals with pre-existing conditions, additional stressors and/or trauma exacerbate symptoms and further impair functionality. If left untreated, the consequences of PTSD have great implications for societal well being. Research indicates that individuals with PTSD have higher rates of suicide and hospitalizations, will be more inclined to abuse alcohol and other drugs, and will have higher utilization rates of medical services.

As Americans continue to heal, it is important to search out resources available in our communities. Statistics report that an unprecedented one in every five people needs mental health care at some point during their lives. Thousands of families and individuals in New York City and throughout the country have benefited from the services of the MHA of NYC. With the resources they provide nationwide, Americans can begin to heal.

MHA of NYC Resources

The NYC 9/11 Benefit Program for Mental Health & Substance Use Services provides NYC residents with financial assistance for outpatient mental health and substance use services. The Benefit works by reimbursing individuals, or their providers, for the costs of mental health treatment.
It's easy to apply, there are no income or citizenship requirements, and reimbursement is retroactive to January 2, 2007.
For more information visit: www.nyc.gov/9-11mentalhealth or call 1 (877) 737-1164.

The benefit provides financial assistance for the following services including:
Outpatient mental health care, Outpatient substance use treatment, Medications related to mental health or substance use treatment, and Psychological evaluations for children under the age of 21

National Suicide Prevention Lifeline 1-800-273-TALK (8255) is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis. Callers are routed to the closest possible crisis center in their area. With more than 130 crisis centers across the country, its mission is to provide immediate assistance to anyone seeking mental health services. All calls are free and confidential.

LIFENET is a free crisis, information and referral service that keeps all calls in the strictest confidence.

If you or someone you know in the New York City area is suffering with emotional or substance abuse problems, we can help. We are here, 7 days a week, 24 hours a day. Our staff of mental health professionals speaks a variety of languages. You can reach us by calling any one of our toll-free, anonymous hotlines:

1-800-LifeNet (1-800-543-3638) (English) 1-877-Ayudese (1-877-298-3373) (Spanish) 1-877-990-8585 (Asian) 1-212-982-5284 (TTY)

Treating Trauma Survivors in a Family Mental Health Clinic

By Tamar Gordon, PhD
and Liane Nelson, PhD
WJCS

Westchester Jewish Community Services' (WJCS) Treatment Center for Trauma and Abuse has been in the forefront in Westchester County in providing child and adult survivors of child sexual abuse with effective treatment for almost thirty years. The program began in the Hartsdale clinic with just two staff and has expanded to three additional WJCS clinics and fourteen members in Peekskill, Mount Vernon and Yonkers. The program strives to provide the best quality of service by understanding and treating the problems associated with childhood sexual abuse, most recently through a focus on evidence-based practice. This focus on evidence-based practice ensures that there is adequate research demonstrating the effectiveness of particular treatment approaches, so that the services provided are of the highest quality.

In this article, we will outline basic information about the impact of child sexual abuse, and how the resulting problems guide treatment goals. We will discuss training provided for professionals through WJCS' Educational Institute on two evidence-based practices for treating adult and child victims of child sexual

abuse: STAIR/NST: Skills Training in Affective and Interpersonal Regulation/ Narrative Storytelling, and Trauma-Focused Cognitive Behavioral Therapy.

A third of the female population in the USA report having had an experience of childhood sexual abuse; one in six men report the same. One in five people, male or female, report physical abuse during childhood (Briere & Elliot, 2003). This means that if you list ten people you know, at work or at home, at least one, probably two, of them are likely to have been abused as a child. This number is even higher in a mental health clinic setting.

Learning during childhood occurs by osmosis; we soak up whatever is around us and make it our own. If you grow up in a household where parents talk about feelings, provide comfort and soothing, and give help when it is needed, you learn how to label your feelings, how to soothe yourself, and how to trust others. Unfortunately, the converse is true as well. If your parents yell at you when you cry, fail to provide basic needs, and abuse you when you need help, you learn to ignore your feelings or let them rage out of control, and to mistrust others. Thus, childhood trauma has a broad impact on adult functioning because it interferes with basic developmental tasks.

Individuals with a history of childhood abuse are at increased risk for repeat victimization, compounding the problems they deal with as adults. They often suffer from post traumatic stress disorder (PTSD) related to their abuse (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995), and experience depression at 3 to 5 times the rate of the rest of population (Breslau, Davis, Peterson, & Schultz, 1997; Putnam, 2003). In addition, they are at increased risk of substance abuse (Breslau, Davis, Schultz, 2003). Childhood trauma and its consequences are topics that cannot be ignored.

At Westchester Jewish Community Services, we are striving to raise awareness of the problems of childhood trauma, as well as train our staff in how best to help survivors. Two classes are offered in the Educational Institute on evidence-based treatments for trauma.

The first class is named STAIR/NST: Skills Training in Affective and Interpersonal Regulation/Narrative Storytelling. The course follows the treatment manual Treating Survivors of Childhood Abuse: Psychotherapy for the Interrupted Life by Cloitre, Cohen, and Koenen. The approach of this treatment is two-fold. First, clients are taught the skills they could not learn in childhood. This includes affect labeling and regulation, distress tolerance, and interpersonal schema therapy. Assertiveness and flexibility in interpersonal relationships are both addressed. The approach is cognitive-behavioral, with a focus on the impact the trauma has had on the developmental acquisition of skills.

The second part of treatment is the Narrative Story Telling, or NST. After the client has learned skills for coping with what can be overwhelming feelings, the trauma memories are directly addressed with NST. It is based on Edna Foa's exposure therapy treatment for PTSD, with modifications to address the unique qualities of childhood trauma memories. PTSD is an anxiety disorder, and, as with any anxiety disorder, the feared stimulus needs to be confronted repeatedly until the anxiety is extinguished through familiarity. This process is called

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Posttraumatic Growth: Positive Psychological Changes After Trauma

By Milton A. Fuentes, PsyD
and Daniel Cruz, MA
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After a trauma, victims, their loved ones and the professional community are often concerned with the subsequent psychological and physical ramifications. There is a plethora of research that documents the deleterious effects of trauma. While it is only natural to want to understand the damaging effects of trauma, newer research is examining the positive psychological effects that may emerge as a result of trauma. Readers may recall adages such as, "What doesn't kill you will only make you stronger" or "Every cloud has a silver lining." These wise sayings were alluding to a phenomenon known as post-traumatic growth (PTG), which has received considerable attention over the past decade. According to Tedeschi and Calhoun (1996), PTG refers to positive psychological changes that an individual experiences as a result of a struggle with highly-challenging life events. They found that some individuals who had experienced trauma often developed a greater appreciation for life, a better way of relating with others, and encountered a spiritual awakening. They also discovered several factors that are associated with

Milton A. Fuentes, PsyD

growth; for example, trauma severity (more severe trauma is associated with greater growth), sex (females tend to experience more PTG than males) and age (positive correlation between age and PTG). This article presents a study that examined PTG after September 11th.

Following the events of September 11th, public awareness initiatives emphasized the potential impact of this event on psychological well-being. Numerous studies examined the psychological distress caused by this event, paying particular attention to post-traumatic stress. The present study assessed PTG in undergraduates living in close proximity to the World Trade Center in New York City on September 11th, 2001. The researchers were interested in examining the relationships between PTG and trauma exposure, psychological mindedness, exposure to trauma and perceived social support. The study participants were 82 college students (Mean age= 26.9 +/- 8.7 yrs, 84% female). The majority self-identified as 3rd or 4th year students (78%), White (52%) and Catholic (48%).

Independent samples t tests were performed in order to compare gender differences on PTGI and Psychological Mindedness. The results indicated a trend whereby woman scored higher on PTGI ($M = 72.64$, $SD = 26.04$) compared to men ($M = 58.15$, $SD = 27.48$), $t(80) = -1.824$, $p<.10$. A similar trend was observed between men and woman on psychological mindedness scales; woman scored higher ($M = 65.88$, $SD = 5.54$) compared to men ($M = 62.92$, $SD = 6.56$), $t(80) = -1.718$, $p<.10$. A bivariate regression analysis was conducted to evaluate the relationship between age and posttraumatic growth. Results show that age was a significant predictor of posttraumatic growth ($\beta = -.277$, $p <.05$).

Results suggest that the study participants experienced post-traumatic growth. Moreover, growth was found to be correlated with psychological mindedness. Specifically, results indicate that dimensions of psychological mindedness (belief in the benefits of discussing one's problems, $r= .25$, $p <.05$; willingness to discuss problems with others, $r= .20$, $p <.05$; and openness to change, $r= .24$ $p <.05$) were positively related to posttraumatic growth. Perceived social support was also positively related to posttraumatic growth ($r= .36$, $p<.05$). Use of resources further contributed to improvements in posttraumatic growth and psychological mindedness. A one-way ANOVA revealed that participants who sought professional resources ($M = 93.1$, $SD = 17.6$) reported the highest posttraumatic growth scores compared to those who sought personal resources ($M = 74.3$, $SD = 27.7$) or no resources ($M = 60.8$, $SD = 23.0$), $F (2, 76) = 6.86$, $p < .05$. Similarly, participants who pursued professional resources also had significantly

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Mental Health News ~ Health and Wellness

Hypothermia

By Colm James McCarthy
Emergency Medical Technician

Getting too hot in summer leads to hyperthermia; getting too cold in winter leads to hypothermia. While getting cold is uncomfortable, if you get too cold it is dangerous. Hypothermia occurs when the temperature of the body stays cooled down despite efforts to stay warm. Knowing hypothermia's symptoms and taking proper precautions can help make winter comfortable, safe, and fun.

Mild symptoms of hypothermia occur not just on cold winter days but also in the summer. Staying in the ocean too long causes our hands and feet to get cold first, our skin to turn pale, our lips to turn blue and we start to shiver. The skin's color change is caused by blood being directed away from skin and towards the inner organs to prevent heat loss. Shivering is the most efficient way to generate heat. If we do not have enough energy to shiver, hypothermia progresses resulting in dangerous and severe symptoms like confusion, fainting, and drowsiness. Eventually, the skin turns black from lack of blood.

Hypothermia is prevented by staying dry and dressing well. This doesn't mean to simply wear warmer clothing, but to

Colm James McCarthy

wear the right clothing correctly. It is easy to avoid getting wet from the outside, but we get wet from the inside by sweating and this can cause hypothermia. Dress in layers, each warmer than the next, and change the layers based on your location and activity. Remove clothing

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Seasonal Affective Disorder

By Richard H. McCarthy, MD, CM, PhD
Research Psychiatrist

While we all have a preferred time of year such as winter for avid skiers and summer for beach volleyball players, there are some people who dread the change of seasons because they have extreme shifts in mood. Some individuals have a full blown depression in the winter. When this occurs year after year, it may be that the person is suffering from Seasonal Affective Disorder (SAD). The symptoms of this form of depression include depressed mood, feelings of hopelessness and/or anxiety, poor concentration, a loss of energy, social withdrawal, and a lack of interest in activities that were previously seen as pleasurable. Weight gain can also occur and there is often an increase in cravings for foods high in carbohydrates. These symptoms typically start in the late fall or early winter and they often stop in the late spring or early summer.

What seems to trigger this illness is not so much a change in the temperature but t a change in the length of the day and night. At the equator days and nights are about equal, 12 hours each, and they remain that way for the year. In the northern hemisphere, the length of the days

Richard H. McCarthy, MD, CM, PhD

varies throughout the year and there are only 2 days when day and night are equal, one is in March and the other is in September. In New York, the amount of time the sun is up decreases every day until late December when it is only light out for approximately 9 ½ hours. After that,

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War Veterans from page 1

The symptom profile of PTSD permits clinicians and researchers to accurately diagnose and better treat and study the consequences of trauma exposure. Yet the experience of a combat veteran suffering from such symptoms encompasses much more than the list of symptoms. According to Dr. Neria, "A returning war veteran may often feel like a different person than he was prior to deployment. For many, being deployed for one or more tours, experiencing life threat, fatigue, and combat stress, is a life changing experience. Upon leaving the war zone and re-entering civilian life, a veteran can feel estranged, out of place, sometimes numb inside, and missing his service members."

The emotional and cognitive injuries associated with war stress have been termed "invisible wounds." Yet their invisibility only seems so at first. Left untreated, the reverberations of war can, in subtle and not-so-subtle ways, erode friendships, sever love relationships, ruin careers and professional aspirations, and dissolve vital bonds with children and parents.

"For some troops, it's as if the war is reenacted in a personal context, destroying everything in its path," said Dr. Neria. PTSD brings the war home not only through vivid re-experiencing of the sensations and images of war, but through bodily and psychological pressures that echo the pressures of combat: insomnia, somatic discomforts, constant expectations of attack, nightmares, loneliness yet aversion to intimacy, self-recriminations, and so on. Over time, a "cascade" of negative outcomes descends. A comprehensive review of the psychosocial impact of war trauma demonstrates elevated rates among veterans of unemployment, divorce, loss of child custody, bankruptcy, incarceration, low emotional well-being, poor physical health, low productivity, and homelessness.[8] Research also shows alarmingly elevated rates of domestic violence in veteran families, as well as secondary trauma among spouses and behavioral, academic and psychiatric problems among children.[9,10,11,12]

Untreated, PTSD can be fatal. Evidence strongly associates PTSD with increased mortality rates from suicide, homicide, "accidental" death, and medical problems such as coronary heart disease and cancer.[8,13,14] Veterans with PTSD frequently have comorbid conditions (27%-75%), including major depressive disorder (MDD), traumatic brain injury (TBI), substance use disorders, and other anxiety disorders.[8] Comorbidity implies greater severity and worse prognosis, and each comorbid condition, in turn, increases risk for negative outcomes.

Current Military Operations

The current military operations in Iraq and Afghanistan constitute a significant public health concern. Over 1.6 million U.S. military personnel have deployed to Iraq or Afghanistan since military operations began in 2001. Operation Iraqi Freedom (OIF), beginning in March, 2003, has been the largest sustained ground operation since Vietnam. The RAND Corporation study[8] estimated 300,000 servicemembers and veterans of OIF and Operation Enduring Freedom (OEF) currently have combat-related PTSD and/or MDD, and approximately 320,000 have TBI.

Matthew J. Kaplowitz, MA

PTSD and TBI have been labeled the signature injuries of the wars in Iraq and Afghanistan. Improved body armor, improved delivery of medical care on the battlefield, and rapid, 24-hour evacuation of injured soldiers to hospitals (versus 45 days in the Vietnam war) have radically shifted the fatality-to-wounded ratio from 1:2.4 in WWII, and 1:3 in Vietnam, to 1:9 in OIF.[8] Soldiers are surviving injuries that once would have been fatal. The most common such injuries in OIF are multiple wounds resulting from improvised explosive device (IED) blasts, which frequently involve head and neck injuries, including severe brain trauma. Such injuries often result from, and constitute in themselves, severely traumatizing experiences, thus increasing risk for PTSD. Studies, in fact, show strong associations between TBI and PTSD, and TBI has also been associated with many negative outcomes, including chronic pain, suicide attempts, physical health problems, cognitive and interpersonal deficits, family difficulties, and other comorbid conditions.[8,16]

Treatment

The consequences of war, though potentially devastating, are treatable. According to Dr. Neria, "Dealing responsibly with stress-injuries through validated, evidenced-based treatments gives a veteran a choice over fate: whether to serve or not, whether to suffer or not."

Evidence-based psychotherapies of proven efficacy for PTSD include exposure therapy[18,19] cognitive therapy[20,21] and eye movement desensitization and reprocessing (EMDR).[22] Other psychotherapy treatments are available for veterans with PTSD, though research is needed to test their efficacy. A current study at the Trauma and PTSD Program is comparing exposure therapy, interpersonal therapy (IPT), and relaxation therapy. Relaxation therapy, in which focus on bodily relaxation leads to decreased anxiety, has performed well in PTSD trials. IPT is a treatment that has demonstrated efficacy for depression and bulimia, and an initial trial found benefits for PTSD patients, focusing on the interpersonal consequences of PTSD.[23] Another study at the Trauma and PTSD Program, scheduled to begin January 2009, will test a six-session, manualized cognitive-behavioral treatment for returning veterans. This study, led by Dr. Neria, introduces an innovative, flexible approach to the treatment of different types of war trauma, including classic fear-conditioned PTSD, traumatic grief, and moral injuries.

"Trauma is heterogeneous," said Dr. Neria, "and exposure treatment doesn't work for everyone. Those suffering pronounced relational conflicts may benefit from an interpersonal approach, while a different approach entirely may be needed for someone who has witnessed or participated in atrocities. Eventually, we want to streamline the patient-treatment matching process, making treatment more efficient. This will also minimize the expense of ineffective treatment." He added, "A similar strategy applies to translational research in which we would like to target specific biological alterations of PTSD and develop more efficient and precise medications to address them."

Effective evidence-based pharmacologic treatments exist for PTSD. Selective serotonin inhibitors (SSRIs) have received the most support to date.[23] Recent evidence suggests that serotonin-noradrenaline reuptake inhibitors (SNRI) may also be effective.[24] Benzodiazepines have shown negative results in clinical trials, and are not appropriate for PTSD treatment.[25]

Treatment for TBI among war veterans is neither well understood nor well researched. A recent, large survey of OIF veterans found the impact of TBI on physical health was mediated by PTSD and MDD, indicating that TBI treatment needs to address its comorbid conditions.[16] Future TBI research should routinely assess for PTSD and MDD and their effect on treatment response.

Access to Treatment

Treating the mental health needs of veterans requires specialized training. The military offers a variety of health care options to veterans and active-duty personnel through the Department of Defense (DoD), most commonly at Military Treatment Facilities (MTFs), and to veterans through the Department of Veteran Affairs (VA), including VA health facilities and clinics, VA polytrauma centers, and Vet Centers. Some veterans may also seek mental health care at civilian facilities financed through the military health care plan, TRICARE.[8]

Military health professionals understand the military culture in which mental health problems among veterans arise, are diagnosed, and treated, but access to such professionals is limited. There is an acute shortage of trained clinicians in the DoD, which suffers from high attrition in mental health personnel due to burn out, low pay, and conflicts in the dual role of officer and practitioner.[8] Servicemembers interested in accessing mental health care face long wait lists, which often results in withdrawal.

Another limitation to access comes from the VA's fixed budget. While there has been increased demand for VA mental health services, this increase does not reflect use by OIF/OEF veterans. Rather, recent demand has been five times greater among veterans from past wars. This may be due to changes in disability benefits, stress associated with aging and retirement, or reactivation of PTSD. At the same time demand for services has increased, the number of visits per patient has decreased by 38% from 1997 to 2005, implying poor continuity of care and higher drop-out rates.[8]

Yet another limitation to access occurs when deactivated reservists return to homes dispersed across the country, often not geographically near MTFs or VA facilities. Besides limited access to care, one study found mental health problems higher among reservists and Guardsmen (42.4%) than active-duty personnel (20.3%).[26] Research to better understand and treat the needs of reservists and Guardsmen is needed.

Barriers to Treatment

The impact of limited access to treatment is substantial. Of the approximately 508,400 servicemembers with PTSD, MDD, or TBI, or some combination of the three, more than two-thirds have not received minimally adequate mental health treatment in the prior year.[8] Yet the lack of care only partly reflects the Veteran Administrations' (VA) fixed resources and the shortage of DoD personnel; it also indicates the stigma military personnel attach to mental health care.

Hoge et al. (2004)[27] found that 60% to 77% of veterans of the Iraq war who screened positive for PTSD, GAD, or MDD did not seek treatment, and were twice as likely as other veterans to report concern about possible stigmatization and other barriers to seeking mental health care. On measures of perceived barriers to care, the most frequently cited items were "I would be seen as weak" (65%) and "My unit leadership might treat me differently" (63%). Similarly, RAND (2008) [8] found that servicemen in need of care endorsed numerous barriers, including concerns that treatment would not be kept confidential (29%), would harm their career (44%), and would lower the respect and confidence of their comrades (38%), leaders (23%) and family (12%).

Evidence suggests that the stigma associated with mental health care is partially an effect of military training.[8,27] War represents a different moral circumstance than society; in fact, a central component of military training involves preparing the conscience for acts of war. This point has no analogy in civilian society, and indeed contradicts civic ethics. Yet conscience matters in war because it can interfere with necessary action, which can, in turn, endanger one's own life and the lives of one's comrades. Therefore, what many soldiers have been trained to fear, perhaps more than death, is the perception of failure or weakness.[1]

This fear is compounded by military culture. Security clearance and career advancement require mental fitness in the eyes of leadership, and among servicemen it is well known that confidentiality in military mental health services is not an option. On a military base, a referral for mental health counseling requires an escort.[8] Applications for security clearance, until recently, inquired about previous mental health care. Most servicemen learn to confide in their comrades, or chaplains, or they just "bury it." [8]

Trust in leadership becomes a still more complex issue in times of war. In the field, servicemen come to trust their

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comrades and often unit commanders with their lives—but this trust does not easily extend up the chain of command, to leaders removed from risks on the front-line. When leadership decisions can endanger one's life, the threshold for tolerating error is lowered.[28]

Mistrust can extend all the way up the ranks. A recruit might experience as a betrayal the fact that current U.S. government has repeatedly changed the rules of deployment, calling servicemen back more frequently and for longer tours.[8] This effect might be intensified among Guardsmen, given the dramatic shift in their role from stateside civic operations to combat overseas. A traumatized soldier might view the VA, devoted exclusively to the medical and mental health needs of war veterans, with mistrust, given its association with the military. A battle-weary soldier might suspect that the interests of the VA, ostensibly in synch with his own, might actually coincide with the military need to patch up and redeploy soldiers.

These barriers to care constitute a public health concern. Many returning servicemen attempt the transition back into civilian life on their own, or with help from family and friends. Yet military returnees face psychological challenges that can negate the best of intentions. They may try to "bury it," but will encounter an unfortunate fact: time does not heal chronic PTSD. The National Vietnam Veterans Readjustment Study (NVVRS) estimated that, in 1998, 15 percent (472,000) of those who had served in Vietnam three decades earlier still met diagnostic criteria for active PTSD. A prospective, longitudinal study of Israeli veterans of the 1982 Lebanon war found that assessments performed [1, 2, 3] and 20 years after combat revealed enduring, severe posttraumatic residues.[29]

"We ought to learn from past mistakes," said Dr. Neria. "and create a supportive, caring environment for returning veterans. Our research program has an ambitious agenda, to test a range of state-of-the-art, evidence-based treatments as part of a broad research portfolio, in order to identify innovative psychotherapy and psychopharmacologic treatments. We want to ensure that the many thousands of veterans close to us in New York have the best care possible. We also aspire to create an effective model for practical and effective treatment that can be adopted elsewhere, and to improve our knowledge about the determinants of combat related PTSD. We believe that treating returning service members in civilian health care facilities, such as the New York State Psychiatric Institute, should appeal to many veterans because of our neutrality, professionalism, and enthusiasm."

Veterans interested in treatment at the Trauma and PTSD Program at CUMC/NYSPI may call (212) 543-6747, or log on to http://columbiatrauma.org. Treatments are funded by research grants and free-of-charge. Confidentiality is ensured as data is monitored with anonymous ID#s, and there are no external communications regarding patient information.

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problem. Others thought they could handle their problems on their own, had difficulty accessing services, experienced financial barriers, or were afraid of treatment (Boscarino, 2005).

Lessons from Project Liberty indicate that for many individuals traumatized in a large-scale disaster, short term crisis counseling intervention is not enough. About 9% of individuals who received counseling through Project Liberty in the first five months following 9/11 were referred to professional mental health services (Covell et al, 2006). The types of psychotherapy available to treat PTSD patients include cognitive-behavioral therapy, exposure therapy, eye movement desensitization and reprocessing, anxiety management, desensitization, and relaxation techniques (American Academy for Experts in Traumatic Stress). Pharmacotherapy used to treat PTSD mainly includes medications that decrease anxiety symptoms in clients and are particularly helpful in conjunction with psychotherapy. The medications that are generally used to help PTSD patients include serotonergic antidepressants (SSRIs) such as Prozac, Zoloft, and Paxil. Research indicates that individuals who continue on antidepressants for approximately one year are less likely to experience a relapse of PTSD (www.medicinenet.com).

Enrollment and Eligibility

If you or someone you know is still suffering psychological symptoms related to the events of 9/11, you may qualify for coverage under the NYC 9/11 Benefit Program. We also encourage mental health providers who treat individuals for conditions related to 9/11 to share information about our program with their clients. Individuals interested in learning more about the program or enrolling may contact 311 or (877) 737-1164 or visit the web at www.nyc.gov/9-11mentalhealth.

Additional Mental Health Services

Apart from the new benefit program, New York City maintains three World Trade Center (WTC) Centers of Excellence that offer free, integrated physical and mental health care to eligible individuals affected by the attack on September 11:

- The WTC Environmental Health Center provides services at Bellevue Hospital Center and Gouverneur Healthcare Services (both in Manhattan) and at Elmhurst Hospital Center (Queens)
- The Mount Sinai Consortium provides services through the WTC Medical Monitoring and Treatment Program
- The Fire Department of New York also participates in the WTC Medical Monitoring and Treatment Program
- New Yorkers seeking a mental health service provider to assess their condition or provide therapy can call 311 or visit www.nyc.gov/9-11healthinfo.

Trish Marsik is the Assistant Commissioner for Mental Health at the NYC Department of Health and Mental Hygiene and JoAnne Mclean is the Director of the NYC 9/11 Benefit Program for Mental Health and Substance Use Services at the NYC Department of Health and Mental Hygiene.

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justice problems and homelessness are major problems. This Policy Academy collaboration will provide support, better coordinate resources and take action to support veterans and their families."

State Health Commissioner Richard F. Daines, MD, said: "Our goal is to create an enhanced service delivery system to address the health care needs of returning veterans and their families. We are committed to working with direct care providers and our federal, state and local partners to make access to needed services as seamless as possible."

State Labor Commissioner M. Patricia Smith said: "The brave men and women of our armed forces fight to defend freedoms at home and abroad every day; and at the Department of Labor, we give priority service to veterans seeking employment assistance through the state's One-Stop Career Centers. We must make employers more aware of the strengths that veterans offer. They have done their duty – now it is up to us to provide training and job opportunities so they can step into a career and build a successful life on their military experience."

New York was chosen to participate based upon a competitive application process. The New York team will continue to meet until October 15, when a comprehensive strategy will be submitted to the Academy coordinators and Governor Paterson for his consideration. Other states and territories chosen to participate include: American Samoa, Florida, Massachusetts, New Hampshire, North Carolina, Oklahoma, South Carolina, Utah and Washington.

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accident; seeing a news report of a sexual assault, which may bring back memories of assault for a woman who was raped.

Avoiding Situations That Remind You of the Event

You may try to avoid situations or people that trigger memories of the traumatic event. You may even avoid talking or thinking about the event. A person who was in an earthquake may avoid watching television shows or movies in which there are earthquakes. A person who was robbed at gunpoint while ordering at a hamburger drive-in may avoid fast-food restaurants. Some people may keep very busy or avoid seeking help. This keeps them from having to think or talk about the event.

Feeling numb - You may find it hard to express your feelings. This is another way to avoid memories. You may not have positive or loving feelings toward other people and may stay away from relationships. You may not be interested in activities you used to enjoy. You may forget about parts of the traumatic event or not be able to talk about them.

Feeling keyed up (also called hyper arousal) - You may be jittery, or always alert and on the lookout for danger. This is known as hyper arousal. It can cause you to: suddenly become angry or irritable, have a hard time sleeping, have trouble concentrating, fear for your safety and always feel on guard, or be very startled when someone surprises you.

What Are Other Common Problems?

People with PTSD may also have other problems. These include: drinking or drug problems, feelings of hopelessness, shame, or despair, employment problems, relationship problems including divorce and violence, and physical symptoms.

Can Children Have PTSD?

Children can have PTSD too. They may have the symptoms described above or other symptoms depending on how old they are. As children get older their symptoms are more like those of adults. Young children may become upset if their parents are not close by, have trouble sleeping, or suddenly have trouble with toilet training or going to the bathroom. Children who are in the first few years of elementary school (ages 6 to 9) may act out the trauma through play, drawings, or stories. They may complain of physical problems or become more irritable or aggressive. They also may develop fears and anxiety that don't seem to be caused by the traumatic event.

Treatment of PTSD

When you have PTSD, dealing with the past can be hard. Instead of telling others how you feel, you may keep your feelings bottled up. But treatment can help you get better.

There are good treatments available for PTSD. Cognitive-behavioral therapy (CBT) is one type of counseling. It appears to be the most effective type of counseling for PTSD. There are different types of cognitive behavioral therapies such as cognitive therapy and exposure therapy. A similar kind of therapy called EMDR, or eye movement desensitization and reprocessing, is also used for PTSD. Medications can be effective too. A type of drug known as a selective serotonin reuptake inhibitor (SSRI), which is also used for depression, is effective for PTSD.

Today, there are good treatments available for PTSD. When you have PTSD dealing with the past can be hard. Instead of telling others how you feel, you may keep your feelings bottled up. But talking with a therapist can help you get better.

Cognitive-behavioral therapy (CBT) is one type of counseling. It appears to be the most effective type of counseling for PTSD. There are different types of cognitive behavioral therapies such as cognitive therapy and exposure therapy. There is also a similar kind of therapy called eye movement desensitization and reprocessing (EMDR) that is used for PTSD. Medications have also been shown to be effective. A type of drug known as a selective serotonin reuptake inhibitor (SSRI), which is also used for depression, is effective for PTSD.

Cognitive Behavioral Therapy - In cognitive therapy, your therapist helps you understand and change how you think about your trauma and its aftermath. Your goal is to understand how certain thoughts about your trauma cause you stress and make your symptoms worse. You will learn to identify thoughts about the world and yourself that are making you feel afraid or upset. With the help of your therapist, you will learn to replace these thoughts with more accurate and less distressing thoughts. You also learn ways to cope with feelings such as anger, guilt, and fear.

After a traumatic event, you might blame yourself for things you couldn't have changed. For example, a soldier may feel guilty about decisions he or she had to make during war. Cognitive therapy, a type of CBT, helps you understand that the traumatic event you lived through was not your fault.

Exposure Therapy - In exposure therapy your goal is to have less fear about your memories. It is based on the idea that people learn to fear thoughts, feelings, and situations that remind them of a past traumatic event.

By talking about your trauma repeatedly with a therapist, you'll learn to get control of your thoughts and feelings about the trauma. You'll learn that you do not have to be afraid of your memories. This may be hard at first. It might seem strange to think about stressful things on purpose. But you'll feel less overwhelmed over time. With the help of your therapist, you can change how you react to the stressful memories. Talking in a place where you feel secure makes this easier.

You may focus on memories that are less upsetting before talking about worse ones. This is called "desensitization," and it allows you to deal with bad memories a little bit at a time. Your therapist also may ask you to remember a lot of bad memories at once. This is called "flooding," and it helps you learn not to feel overwhelmed. You also may practice different ways to relax when you're having a stressful memory. Breathing exercises are sometimes used for this.

EMDR - Eye movement desensitization and reprocessing (EMDR) is a fairly new therapy for PTSD. Like other kinds of counseling, it can help change how you react to memories of your trauma. While talking about your memories, you'll focus on distractions like eye movements, hand taps, and sounds. For example, your therapist will move his or her hand near your face, and you'll follow this movement with your eyes. Experts are still learning how EMDR works. Studies have shown that it may help you have fewer PTSD symptoms. But research also suggests that the eye movements are not a necessary part of the treatment.

Medication - Selective serotonin reuptake inhibitors (SSRIs) are a type of antidepressant medicine. These can help you feel less sad and worried. They appear to be helpful, and for some people they are very effective. SSRIs include citalopram (Celexa), fluoxetine (such as Prozac), paroxetine (Paxil), and sertraline (Zoloft). Chemicals in your brain affect the way you feel. When you have or depression you may not have enough of a chemical called serotonin. SSRIs raise the level of serotonin in your brain. There are other medications that have been used with some success. Talk to your doctor about which medications are right for you.

Group Therapy - Many people want to talk about their trauma with others who have had similar experiences. In group therapy, you talk with a group of people who also have been through a trauma and who have PTSD. Sharing your story with others may help you feel more comfortable talking about your trauma. This can help you cope with your symptoms, memories, and other parts of your life.

Group therapy helps you build relationships with others who understand what you've been through. You learn to deal with emotions such as shame, guilt, anger, rage, and fear. Sharing with the group also can help you build self-confidence and trust. You'll learn to focus on your present life, rather than feeling overwhelmed by the past.

Brief Psychodynamic Psychotherapy - In this type of therapy, you learn ways of dealing with emotional conflicts caused by your trauma. This therapy helps you understand how your past affects the way you feel now.

Your therapist can help you: identify what triggers your stressful memories and other symptoms, find ways to cope with intense feelings about the past, become more aware of your thoughts and feelings so you can change your reactions to them, and raise your self-esteem.

Family Therapy - PTSD can impact your whole family. Your kids or your partner may not understand why you get angry sometimes, or why you're under so much stress. They may feel scared, guilty, or even angry about your condition. Family therapy is a type of counseling that involves your whole family. A therapist helps you and your family communicate, maintain good relationships, and cope with tough emotions. Your family can learn more about PTSD and how it is treated.

In family therapy, each person can express his or her fears and concerns. It's important to be honest about your feelings and to listen to others. You can talk about your PTSD symptoms and what triggers them. You also can discuss the important parts of your treatment and recovery. By doing this, your family will be better prepared to help you. You may consider having individual therapy for your PTSD symptoms and family therapy to help you with your relationships.

How Long Does Treatment Last?

For some people, treatment for PTSD can last 3 to 6 months. If you have other mental health problems as well as PTSD, treatment for PTSD may last for 1 to 2 years or longer.

What if Someone Has PTSD and Another Disorder? Is the Treatment Different?

It is very common to have PTSD at that same time as another mental health problem. Depression, alcohol or substance abuse problems, panic disorder, and other anxiety disorders often occur along with PTSD. In many cases, the PTSD treatments described above will also help with the other disorders. The best treatment results occur when both PTSD and the other problems are treated together rather than one after the other.

What Will We Work On in Therapy?

When you begin therapy, you and your therapist should decide together what goals you hope to reach in therapy. Not every person with PTSD will have the same treatment goals. For instance, not all people with PTSD are focused on reducing their symptoms.

Some people want to learn the best way to live with their symptoms and how to cope with other problems associated with PTSD. Perhaps you want to feel less guilt and sadness? Perhaps you would like to work on improving your relationships at work, or communication issues with your friends and family. Your therapist should help you decide which of these goals seems most important to you, and he or she should discuss with you which goals might take a long time to achieve.

What Can I Expect From My Therapist?

Your therapist should give you a good explanation for the therapy. You should understand why your therapist is choosing a specific treatment for you, how long they expect the therapy to last, and how they see if it is working. The two of you should agree at the beginning that this plan makes sense for you and what you will do if it does not seem to be working. If you have any questions about the treatment your therapist should be able to answer them.

You should feel comfortable with your therapist and feel you are working as a team to tackle your problems. It can be difficult to talk about painful situations in your life, or about traumatic experiences that you have had. Feelings that emerge during therapy can be scary and challenging. Talking with your therapist about the process of therapy, and about your hopes and fears in regards to therapy, will help make therapy successful. If you do not like your therapist or feel that the therapist is not helping you, it might be helpful to talk with another professional. In most cases, you should tell your therapist that

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you are seeking a second opinion.

How Common is PTSD?

Posttraumatic stress disorder (PTSD) can occur after you have been through a traumatic event. A traumatic event is something horrible and scary that you see or that happens to you. During this type of event, you think that your life or others' lives are in danger. You may feel afraid or that you have no control over what is happening.

Experiencing a traumatic event is not rare. About 60% of men and 50% of women experience this type of event in their lives. Women are more likely to experience sexual assault and child sexual abuse. Men are more likely to experience accidents, physical assault, combat, disaster or to witness death or injury.

But going through a traumatic event doesn't mean you'll get PTSD. About 8% of men and 20% of women develop PTSD after a traumatic event.

Here are some facts:

- In the United States, about 8% of the population will have PTSD symptoms at some point in their lives.
- About 5.2 million adults have PTSD during a given year. This is only a small portion of those who have experienced a traumatic event.
- Women are more likely than men to develop PTSD. About 10% of women develop PTSD compared with 5% of men.
- Women are more likely than men to develop PTSD for all types of traumatic events, except sexual assault or abuse. When these traumas occur, men are just as likely as women to get PTSD.

Who is Most Likely to Develop PTSD?

Most people who experience a traumatic event will not develop PTSD. However, you are more likely to develop PTSD if you: were directly exposed to the traumatic event as a victim or a witness, were seriously injured during the event, went through a trauma that was long lasting or very severe, believed that you were in danger, believed that a family member was in danger, had a severe reaction during the event, such as crying, shaking, vomiting, or feeling apart from your surroundings, or have felt helpless during the trauma and were not able to help yourself or a loved one.

You are also more likely to develop PTSD if you: had an earlier life-threatening event or trauma, such as being abused as a child, have another mental health problem, have family members who have had mental health problems, have little support from family and friends, have recently lost a loved one, especially if it was unexpected, have had recent, stressful life changes, drink a lot of alcohol, are a woman, are poorly educated, or are younger.

Some groups of people, including blacks and Hispanics, may be more likely than whites to develop PTSD. This may be because these groups are more likely to experience a traumatic event. For example, in veterans who survived Vietnam, a larger percent of blacks, Hispanics, and Native Americans were in combat than whites. Your culture or ethnic group also may affect how you react to PTSD. For example, people from groups that are open and willing to talk about problems may be more willing to seek help.

PTSD and the Military

If you are in the military, you may have seen combat. You may have been on missions that exposed you to horrible and life-threatening experiences. You may have been shot at, seen a buddy shot, or seen death. These are types of events that can lead to PTSD.

Experts think PTSD occurs: in about 30% of Vietnam veterans, or about 30 out of 100 Vietnam veterans, in as many as 10% of Gulf War (Desert Storm) veterans, or in 10 veterans out of 100.9, in about 6% to 11% of veterans of the Afghanistan war (Enduring Freedom), or in 6 to 11 veterans out of 100, and in about 12% to 20% of veterans of the Iraq war (Iraqi Freedom), or in 12 to 20 veterans out of 100.

Other factors in a combat situation can add more stress to an already stressful situation and may contribute to PTSD and other mental health problems. These factors include what you do in the war, the politics around the war, where it's fought, and the type of enemy you face.

Another cause of PTSD in the military can be military sexual trauma (MST). This is any sexual harassment or sexual assault that occurs while you are in the military. MST can happen to men and women and can occur during peacetime, training, or war.

Among veterans using VA health care, about 23 out of 100 women (23%) reported sexual assault when in the military and 55 out of 100 women (55%) and 38 out of 100 men (38%) have experienced sexual harassment when in the military. Even though military sexual trauma is far more common in women, over half of all veterans with military sexual trauma are men.

Helping a Family Member Who Has PTSD

When someone has PTSD, it can change family life. The person with PTSD may act differently and get angry easily. He or she may not want to do things you used to enjoy together. You may feel scared and frustrated about the changes you see in your loved one. You also may feel angry about what's happening to your family, or wonder if things will ever go back to the way they were. These feelings and worries are common in people who have a family member with PTSD.

It is important to learn about PTSD so you can understand why it happened, how it is treated, and what you can do to help. But you also need to take care of yourself. Changes in family life are stressful, and taking care of yourself will make it easier to cope.

How Can I Help?

You may feel helpless, but there are many things you can do. Nobody expects you to have all the answers. Learn as much as you can about PTSD. Knowing how PTSD affects people may help you understand what your family member is going through. The more you know, the better you and your family can handle PTSD. Offer to go to doctor visits with your family member. You can help keep track of medicine and therapy, and you can be there for support. Tell your loved one you want to listen and that you also understand if he or she doesn't feel like talking. Plan family activities together, like having dinner or going to a movie. Take a walk, go for a bike ride, or do some other physical activity together. Exercise is important for health and helps clear your mind. Encourage contact with family and close friends. A support system will help your family member get through difficult changes and stressful times.

Your family member may not want your help. If this happens, keep in mind that withdrawal can be a symptom of PTSD. A person who withdraws may not feel like talking, taking part in group activities, or being around other people. Give your loved one space, but tell him or her that you will always be ready to help.

How Can I Deal with Anger or Violent Behavior?

Your family member may feel angry about many things. Anger is a normal reaction to trauma, but it can hurt relationships and make it hard to think clearly. Anger also can be frightening. If anger leads to violent behavior or abuse, it's dangerous. Go to a safe place and call for help right away. Make sure children are in a safe place as well.

It's hard to talk to someone who is angry. One thing you can do is set up a time-out system. This helps you find a way to talk even while angry. Agree that either of you can call a time-out at any time. Agree that when someone calls a time-out, the discussion must stop right then. Decide on a signal you will use to call a time-out. The signal can be a word that you say or a hand signal. Agree to tell each other where you will be and what you will be doing during the time-out. Tell each other what time you will come back.

While you are taking a time-out, don't focus on how angry you feel. Instead, think calmly about how you will talk things over and solve the problem. After you come back, take turns talking about solutions to the problem. Listen without interrupting. Use statements starting with "I," such as "I think" or "I feel." Using "you" statements can sound accusing. Be open to each other's ideas and don't criticize each other. Focus on things you both think will work. It's likely you will both have good ideas. Together, agree which solutions you will use.

How Can I Communicate Better?

You and your family may have trouble talking about feelings, worries, and everyday problems. To communicate better, be clear and to the point and be positive. Blame and negative talk won't help the situation. Be a good listener. Don't argue or interrupt. Repeat what you hear to make sure you understand, and ask questions if you need to know more. Put your feelings into words. Your loved one may not know you are sad or frustrated unless you are clear about your feelings. Help your family member put feelings into words. Ask, "Are you feeling angry? Sad? Worried?" Ask how you can help. Don't give advice unless you are asked.

If your family is having a lot of trouble talking things over, consider trying family therapy. Family therapy is a type of counseling that involves your whole family. A therapist helps you and your family communicate, maintain good relationships, and cope with tough emotions. During therapy, each person can talk about how a problem is affecting the family. Family therapy can help family members understand and cope with PTSD. Your health professional or a religious or social services organization can help you find a family therapist who specializes in PTSD.

How Can I Take Care of Myself?

Helping a person with PTSD can be hard on you. You may have your own feelings of fear and anger about the trauma. You may feel guilty because you wish your family member would just forget his or her problems and get on with life. You may feel confused or frustrated because your loved one has changed, and you may worry that your family life will never get back to normal.

All of this can drain you. It can affect your health and make it hard for you to help your loved one. If you're not careful, you may get sick yourself, become depressed, or burn out and stop helping your loved one. To help yourself, you need to take care of yourself and have other people help you.

Don't feel guilty or feel that you have to know it all. Remind yourself that nobody has all the answers. It's normal to feel helpless at times. Don't feel bad if things change slowly. You cannot change anyone. People have to change themselves. Take care of your physical and mental health. If you feel yourself getting sick or often feel sad and hopeless, see your doctor. Don't give up your outside life. Make time for activities and hobbies you enjoy. Continue to see your friends. Take time to be by yourself. Find a quiet place to gather your thoughts and "recharge." Get regular exercise, even just a few minutes a day. Exercise is a healthy way to deal with stress. Eat healthy foods. When you are busy, it may seem easier to eat fast food than to prepare healthy meals. But healthy foods will give you more energy to carry you through the day. Remember the good things. It's easy to get weighed down by worry and stress. But don't forget to see and celebrate the good things that happen to you and your family.

During difficult times, it is important to have people in your life that you can depend on. These people are your support network. They can help you with everyday jobs, like taking a child to school, or by giving you love and understanding. You may get support from: family members, friends, coworkers, neighbors, members of your religious or spiritual group, support groups, and doctors and other health professionals

What Can I Do if I Think I Have PTSD?

If you think you have PTSD, it's important to get treatment. Treatment can work, and early treatment may help reduce long-term symptoms. If you think you have PTSD, talk to your family doctor. Talk to a mental health professional, such as a therapist. If you're a veteran, contact your local VA hospital or Vet Center. Talk to a close friend or family member. He or she may be able to support you and find you help. Talk to a

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religious leader. Fill out a PTSD screen (www.ncptsd.va.gov/ncmain/ncdocs/assmnts/the_primary_care_ptsd_screen_pcptsd.html) and take it with you to the doctor. An online PTSD screen is available for PTSD related to stressful military experiences, but you can also answer the questions as they would apply to any other traumatic event.

Many people who might need assistance with something like the symptoms of PTSD are afraid to go for help. 1 out of 5 people say they might not get help because of what other people might think. 1 out of 3 people say they would not want anyone else to know they were in therapy.

A study that's been done of soldiers coming home from Iraq found that only 4 in 10 service members with mental health problems said they would get help. Some of the most common reasons they gave were: worried about what others would think, thought it might hurt their military career, might be seen as weak.

Why Seek Help?

Early treatment is better. Symptoms of PTSD may get worse. Dealing with them now might help stop them from getting worse in the future. Finding out more about what treatments work, where to look for help, and what kind of questions to ask can make it easier to get help and lead to better outcomes.

PTSD symptoms can change family life. PTSD symptoms can get in the way of your family life. You may find that you pull away from loved ones, are not able to get along with people, or that you are angry or even violent. Getting help for your PTSD can help improve your family life.

PTSD can be related to other health problems. PTSD symptoms can worsen physical health problems. For example, a few studies have shown a relationship between PTSD and heart trouble. By getting help for your PTSD you could also improve your physical health.

It may not be PTSD. Having symptoms of PTSD does not always mean you have PTSD. Some of the symptoms of PTSD are also symptoms for other mental health problems. For example, trouble concentrating or feeling less interested in things you used to enjoy can be symptoms of both depression and PTSD. And, different problems have different treatments.

While it may be tempting to identify PTSD for yourself or someone you know, the diagnosis generally is made by a mental-health professional. This will usually involve a formal evaluation by a psychiatrist, psychologist, or clinical social worker specifically trained to assess psychological problems.

If you do not want to be evaluated but feel you have symptoms of PTSD you may choose "watchful waiting." Watchful waiting means taking a wait-and-see approach. If you get better on your own, you won't need treatment. If your symptoms do not get better after 3 months and they are either causing you distress or are getting in the way of your work or home life, talk with a health professional.

In a few cases, your symptoms may be so severe that you need immediate help. Call 911 or other emergency services immediately if you think that you cannot keep from hurting yourself or someone else.

Communities from page 25

exposure phase of the treatment, clients repeatedly tell their trauma stories, adding more and more detail, while also learning to cope with their emotional reactions. In addition, clients examine dysfunctional beliefs, such as shame and blame, during this phase of treatment. Examples are Trauma-Focused Cognitive Behavioral Therapy for children and adolescents, Life Skills/Life Story for adolescents, and Cognitive Processing Therapy for adults. Prolonged Exposure is another evidence-based treatment which involves the same central features, with a greater emphasis on exposure. Other treatments include exposure through Virtual Reality and Eye Movement Desensitization and Reprocessing (EMDR).

For children exposed to multiple traumas who have PTSD and a more complex post-traumatic picture, treatments include Child-Parent Psychotherapy (CPP), Trauma Systems Therapy (TST), Attachment, Self-Regulation and Competency (ARC), and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). Psychopharmacology as a sole treatment, or combined with psychotherapy, can also be used for adults and some children.

Treatment is best conducted in a culturally informed manner – lives and trauma occur in a context. Attention to micro-aggressions, as well as overt racism is crucial. Respect for language and traditional understanding of symptoms and their function is important and treatment in native language is critical. Community support, both culturally informed and meaningful to the individual and family, has been shown to enhance engagement and support successful treatment.

Non-evidence informed treatments are often sought by individuals (and evidence is emerging to support their value). These include spiritual approaches, yoga, body work, and expressive treatments. Often, due to the disorganizing effects of trauma, survivors have difficulty verbalizing what happened to them or their feelings. Expressive mediums, such as art, music, dance, poetry and drama, enable the client to express feelings, organize and structure their experiences, and process the trauma in a safe, non-threatening way.

At its core, PTSD is a disorder that creates powerlessness. By definition, sufferers experienced an event of overwhelming terror or horror. Gaining mastery in a variety of domains, therefore, can create a sense of self worth and confidence. Physical activity in which a person experiences strength, power and confidence can help to undo the feelings of powerlessness and isolation. Team-based sports, karate, self-defense and dance are examples of recommended activities. Support groups in a variety of community settings, for victims and their families, can do the same. Reconciliation of the horrors witnessed, the innocence lost, and the grief experienced require treatment, community support and an individualized "best match" approach.

Help is available. Mental health practitioners can enhance their skills in assessment and treatment of PTSD. JBFCS offers courses and consultations in trauma assessment and treatment. Online and in-person courses are also offered at many New York settings and on the websites including: www.ncptsd.va.gov; www.nctsn.org; www.istss.org; tfcbt.musc.edu; www.agpa.org. Consultations and collaborations are the best way to enhance individual and agency capacity. When doing trauma-informed work, avoiding secondary traumatic consequences is best achieved by not doing the work alone.

JBFCS programs address trauma and PTSD using evidence-based interventions in young children, school age children & adolescents in clinics, day programs and residential care (PCP, Sanctuary®, SPARCS, TF-CBT, Life Skills/Life Story, adults in clinics (CPT & CBT). Early intervention is done through evidence-informed Crisis Response, Psychological Preparedness Groups (Keep It REAL) and Community Psychoeducation. For more information call 212-632-4519; ppanzer@jbfcs.org; www.jbfcs.org. Member, National Child Traumatic Stress Network.

This article was written by the JBFCS Center for Trauma Program Innovation and Martha K. Selig Educational Institute Team. Paula G. Panzer, MD, Director. Staff: Randi Anderson; Melanie Cushman; Mary Dino; Amy Feldman; Christina Grosso; Deborah Langosch; Susan Paula; Linda Payne; Caroline Peacock; and Alice Psirakis.

SAD from page 31

the amount of sun light increases every day until late June when we have the longest day of the year and it is only dark for approximately 9 ½ hours.

It is probably not a coincidence that some people get depressed as the days shorten and then improve as the days lengthen again. It was this observation that lead people to look to light as a way of treating this unusual form of depression. Light therapy is often a major treatment for Seasonal Affective Disorder. While this treatment is not yet approved by the FDA, it is very commonly used. A very bright light is used, much brighter than the ordinary lights in a house. This artificial light is thought to mimic the effect of outdoor light and likely results in biochemical changes in the brain. Typically a person purchases a "light box" that produces approximately 10.000 lux (a measure of light intensity). For comparison, the lighting in an average living room is usually less than 500 lux. It is not necessary to stare at the light, just sit very close to the light box for approximately 30 minutes each morning and read (the closer the better, because light intensity falls off quite rapidly with distance). As amazing as this sounds, this is often enough to treat the depression.

However, before you try this at home check with your doctor. The illness, depression, can be a symptom of a lot of other problems. Before you make your own decisions on the problem and the solution, speak with a physician.

Veterans from page 17

days of the war report that the military did a poor job in preparing them emotionally for the transition back to civilian life. As a result, some veterans began experiencing issues with anger, depression and substance abuse. Some lost their jobs and their marriages, some got into trouble with the law, others committed suicide. These tragedies might have been averted had the veteran been made aware of what services were available.

In response, the Veterans Health Alliance of Long Island, in partnership with NYS Assemblywoman Michelle Schimel, and the Nassau County Veterans Service Agency produced a brochure that explained PTSD and where veterans could go for assistance. This brochure was mailed to over 3,100 veterans who returned home to Nassau County since 9/11/01.

The Veterans Health Alliance continues to look for new ways to reach out to veterans and will seek to make better use of the internet to offer veterans the chance to obtain resources and information in an anonymous fashion.

Program and Training: The Veterans Health Alliance of Long Island has partnered with the OMH and OASAS Long Island Field offices to conduct training for providers and other stakeholders. The training gives providers, who may not be familiar with the military, an overview of the military "culture." The training also educates providers in new techniques to aid recovery from combat related PTSD, including the US Army "Battlemind" concept.

"Battlemind" points out to the veteran that the military trains people to be aggressive, to carry weapons at all times, to give and take orders, to be secretive, and to drive fast. While these are all strengths in a combat environment, these behaviors can be problematic if not adjusted for civilian life. Battlemind helps soldiers build on their strengths in order to make a smoother transition.

In addition to Battlemind, Veterans and their families are taught that a traumatic experience of combat produces chemical changes in the brain, and that this is a "normal" reaction. Veterans and their families are also instilled with the hope and belief that PTSD is curable.

Advocacy: Members of the Veterans Health Alliance of Long Island have met with elected officials on the county, state, and federal levels in order to advocate for improved behavioral health and support services for veterans and their family members.

In conclusion, the vision of the Veterans Health Alliance of Long Island is: "You Served Your Country, Now Let Your Community Serve You." Working together, community providers, government agencies, and elected officials can help our veterans combat the effects of trauma and depression and achieve peace of mind.

Mr. Javis is Chairman of the Veterans Health Alliance of Long Island.

Combat from page 17

current conflicts drag on, while still caring for veterans of previous wars. Their resources have become overburdened. Moreover, many National Guardsmen and Reservists do not live near military posts and VA centers to be able to easily access care even if they did overcome their reluctance to seek help.

The civilian mental health system, then, is quickly becoming the last best treatment alternative for veterans and their families. Mental health agencies are beginning to recognize this as they prepare their clinicians for what will be an increasing number of veterans and families of veterans in need of treatment. On Long Island, which has the second largest concentration of veterans in the county, the Mental Health Association of Nassau County and State Office of Mental Health's Long Island Regional Office have led an effort to form the Veterans Health Alliance of Long Island, which Catholic Charities and a number of other non-profit agencies have joined. The purpose of the Alliance is to increase awareness of our community services among veterans and their families and provide training for civilian clinicians on how to effectively assess and treat combat related post traumatic stress and its impact on family members. The Alliance is also engaged in advocacy efforts to secure legislation that will provide a more comprehensive approach to mobilizing resources across New York State to assure veterans, and their families, access to needed services and supports.

The psychological impact of war on our soldiers and their families is not very visible to the public but is nonetheless shocking when examined. The advocacy organization, Iraq and Afghanistan Veterans of America, has compiled data from various legitimate private and government sources that begs attention. For example, at least 30 to 40% of Iraq veterans, or about half a million people nationally, will face a serious psychological wound, including depression, anxiety, or PTSD. Multiple tours and inadequate time at home between deployments increase rates of combat stress by 50%. Twenty percent of married troops in Iraq say they are planning a divorce. At least 40,000 Iraq and Afghanistan veterans have been treated at a VA hospital for substance abuse. And these represent only those who actually seek help. The current Army suicide rate is the highest it has been in 26 years. Since the start of the wars, there have been a total of 147 military suicides in Iraq and Afghanistan (Mental Health Injuries: The Invisible Wounds of War," January 2008). These statistics are not dissimilar to those experienced by Viet Nam veterans, a conflict in which more than three million Americans served over the course of that 10 year war. And psychiatric casualties among surviving World War II and Korean War veterans do indeed exist but have received far less attention.

As a society, we must recognize that when we commit our nation to war, there will be consequences that reach far beyond the eventual peace treaties. And we must be prepared not only to honor our veterans who place themselves in harm's way, but to provide them the care and resources necessary to put their lives back together after exiting the gates of hell that is war.

Survivors from page 29

habituation. An example of simple exposure therapy would be a fear of dogs that is eliminated through spending time with puppies, and then with bigger dogs. In PTSD, the feared stimuli are the memories of abuse, and clients go to great lengths to try to avoid them. Unfortunately, avoidance does not make the memories go away and can cause significant functional disturbance. Thus, the memories must be spoken about until habituation occurs. The act of remembering and speaking about the memories is referred to as imaginal exposure.

The fear of abuse memories, however, is not quite as simple as our dog phobia example. Trauma is taboo, rarely discussed, and as a result its meaning is not processed. The client's childhood is like a puzzle that has not been put together, and she is often left with beliefs about her history that have not been updated; her life narrative is fragmented. In NST, the client not only goes through imaginal exposure to habituate to her memories, she also applies schema therapy to her memories with the help of her therapist. She works on understanding her history, and putting it into the context of an ongoing, hopeful, future-oriented life.

The second evidence-based trauma treatment taught at WJCS is focused on child treatment. It is named Trauma Focused Cognitive Behavioral Therapy, and is the current state-of-the-art treatment for child sexual abuse victims based on work by Judith Cohen, Anthony Mannarino, and Esther Deblinger.

This treatment approach incorporates work with the child and the parent(s), both separately and together. Psychoeducation is provided for both the child and parent(s) to help them understand that the trauma symptoms and reactions they are experiencing are normal. The child is taught coping skills for managing stress, including how to identify different emotions, how to manage intense and negative emotions, and how to "talk back" to negative thoughts. Parents are considered an important part of the therapy team, and so they also meet with the therapist to learn the same coping skills to support the use of these skills outside of the therapy hour. Parent skill building helps guide effective behavior management in the home.

Once these coping skills have been mastered, the child works on a trauma narrative. The narrative is later shared with the parents so that the parents can demonstrate that they can tolerate and support their child in telling their story. Working on, and telling the trauma narrative helps the child stop avoiding memories and reminders as well as placing the trauma in the context of something that happened in the past. This treatment has been shown to be most effective in reducing Post Traumatic Stress Disorder symptoms in children and is quite effective in allowing children to heal from the trauma of sexual abuse.

WJCS is very proud of the work that we do to help adult and child sexual abuse victims. We welcome our colleagues around the New York State area to take part in the Educational Institute classes, and encourage the use of evidence based treatment in all treatment centers.

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greater scores on psychological mindedness (M = 69.1, SD = 4.5) compared to participants who sought personal resources (M = 66.0, SD = 6.1) or no resources (M = 64.3, SD = 5.4), $F(2, 76) = 3.16$, $p < .05$.

The goal of this study was to explore factors that are associated with the development of posttraumatic growth. The results suggest that psychological mindedness significantly contributed to posttraumatic growth. Specifically, we found significant relationships among belief in the benefits of discussing one's problems, willingness to discuss problems with others, openness to change and scores on posttraumatic growth. Furthermore, students who reported perceived social support also tended to report greater gains in scores on posttraumatic growth. Students who participated in the use of professional resources such as psychotherapy indicated significantly greater scores on posttraumatic growth and psychological mindedness.

This study broadens our understanding of post-traumatic growth and identifies the factors that foster its development. These findings easily inform clinical interventions and community models aimed at helping individuals more successfully respond to traumatic events. When it comes to treatment, it is important to tailor the approach around the unique needs of the patient; however, generally speaking, trauma victims are encouraged to speak immediately after the trauma and to speak often about the trauma. While clinicians may be tempted to explore early on the positive implications that may emerge as a result of the trauma, it is important to resist that urge. Positive reframing or assessing the benefits prematurely can prevent trauma victims from fully processing the event (Calhoun and Tedeschi, 2004). To learn more about PTG and its clinical implications, readers are advised to review Calhoun and Tedeschi's (2004) article, The Foundations of Posttraumatic Growth: New Considerations. Resick, Monson and Rizvi (2007) also provide a step-by-step treatment approach for treating posttraumatic stress disorder. This chapter can be found in Barlow's (2007) Clinical Handbook of Psychological Disorders.

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Legal Case from page 9

it will only lead to more questions." In another email by the VA's mental health director, when discussing the high rate of suicide stated, "is this something we should (carefully) address ourselves in some sort of release before someone stumbles on it?"

From this evidence it appeared clear that there was a wide ranging and systemic problem within the VA and its treatment of returning soldiers suffering from PTSD and other mental health disorders. The Court agreed, concluding that there were inadequacies and deficiencies within the VA system. Despite this finding, the Court ultimately dismissed the case, for many potentially unsatisfying reasons. In essence the Court concluded that the relief the plaintiffs sought in the case, ostensibly an expansive overhaul of the VA's procedures was outside the scope of the Court's powers. The Court concluded that for such systemic and far reaching change to take place, it will require an act of Congress or perhaps the Executive branch, which after all, controls the VA.

The Federal Court's conclusion undoubtedly is an extremely troubling result for many. While finding major flaws and problems in the way in which the VA exercises its legal obligations to provide health care to veterans, the Court refused to act citing a spurious conclusion based on its inability to act in an executive or legislative capacity. Many of us look to the judicial branch of government to uphold concepts of fairness and protect our rights where other areas of the government will not. Unfortunately, the Court seems to have neglected that duty here. While true that the oversight of an overhaul of such a huge bureaucracy as the VA, which serves millions of veterans, is a herculean task to say the least, Courts have taken on, albeit smaller in scope, large overhauls of constitutionally deficient institutional systems such as schools and prisons.

For those who feel as though the court erred in its dismissal of the suit, take heart in the fact that the plaintiffs have filed for an appeal to the Ninth Circuit Court of Appeals. Quite possibly an Appellate Court will not be as reticent as the District Court to assert its authority. To be sure, a contrary ruling by the Ninth Circuit would undoubtedly lead to an appeal to the United States Supreme court.

Conclusion

If nothing else, it is clear that a greater effort must be made by our government in general, and the VA in specific, to properly treat and diagnose soldiers returning from war. These men and women simply deserve no less. It is encouraging to know, however, that groups such as Veterans for Common Sense and Veterans United for Truth are willing to fight to ensure that soldiers obtain the benefits they so valiantly earned. Even if the present lawsuit is no more successful on appeal than it already has been, surely the negative attention brought to the plight of soldiers suffering with mental illness will garner a greater level of care and treatment; if for no other reason than to avoid the harmful publicity.

Hypothermia from page 31

layers when you are inside or outside and being physically active. Too much clothing causes overheating and sweating. Put clothing layers on when you are you outside or when you are inactive. Adding and removing layers is crucial for active people because wet and sweaty skin cools 200 times faster than dry skin. To stay warm, you must stay dry.

Do not wear cotton. Cotton holds onto moisture and will keep you wet and therefore cold. Your cotton hooded sweatshirt will not help you prevent hypothermia; cotton can kill you in the cold. Wear "wicking" fabrics like, wool, silk, or synthetic fabrics (fleece) that help move moisture away from the skin. Start your layers with wicking long underwear followed by warm pants and a heavy shirt. Next is a fleece, vest, or heavy sweater. Finish with a warm winter jacket to block the wind. Eighty percent of the body heat is lost from the head, so make sure you put on a hat!

Hypothermia treatment starts with getting out of the wind and cold, changing into warm dry clothing and slowly drinking something warm and non-alcoholic. Alcohol may make you feel warm, but it makes you cold by causing the skin to flush. Warmed blankets from the dryer or radiator are great, but avoid electric blankets as they can cause overheating or burns. Gently hold and rub the skin if it is pale but avoid aggressive or prolonged rubbing since cold skin is numb and aggressive rubbing results in friction burns. In all cases of mild hypothermia, if the person cannot get warm, go to the hospital. If the person is confused, cannot stay awake, or has black skin, immediately call 911. As always, prevention is best. Proper dress and attention to overheating will prevent hypothermia and will help you to enjoy the winter.

Group Work from page 19

empowering counterforce to the dissolution of the bonds that link people to one another in the aftermath of collective trauma; and the accompanying disorientation, demoralization, and loss of connection. Group work is a potent tool for assisting young people to grieve; developing coping skills to counter traumatic grief; giving voice and encouraging action; and promoting resilience in the face of the most adverse conditions.

Portions of this article are drawn from a book chapter (10) by Andrew Malekoff ("Transforming the trauma of September 11, 2001, with children and adolescents through group work") that appears in Transforming Trauma: An Empowerment Approach, Eds. Judith Wise and Marian Bussey, New York: Columbia University Press, 2007, 194-219. Andrew Malekoff, LCSW, CASAC is executive director/CEO for North Shore Child and Family Guidance Center in Roslyn Heights, New York; and Editor-in-Chief of Social Work with Groups, a journal of community and clinical practice, published by Taylor & Francis.

Sexual Abuse from page 19

has been critical in helping three of these children at South Shore Child Guidance Center heal from the effects of Post Traumatic Stress Disorder due to sexual abuse.

As mentioned earlier, Trauma Based Cognitive Therapy is implemented in segments. These segments include; psycho-education, stress management, affect expression and modulation, cognitive coping, creating the trauma narrative, cognitive processing, behavior management training, and facilitating parent and child sessions (Cohen, J.A., Mannarino, A.P., & Deblinger, E. 2006).

Children who are sexually abused often blame themselves for the abuse. Psycho-education is essential in the therapeutic process in order to clarify inappropriate information given to the child by the perpetrator.

The following vignettes illustrate 3 cases from South Shore Child Guidance Center's clients.

"Emma" was referred for treatment due to suffering from PTSD since she was sexually abused by her mothers' boyfriend at the age of nine. Initially, she was provided psycho education regarding the different types of trauma, causes of trauma, effects of the trauma, as well as normalizing the resistance to discuss sexual abuse. Furthermore, psycho education should entail the discussion of the correct names of body parts, as well as safety planning to avoid re-victimization. Throughout treatment, "Emma" learned methods to reduce stress, such as deep breathing techniques and was provided a meditation CD in order for her to practice at home. She recorded the times that she practiced the deep breathing techniques on paper. "Emma" was also able to teach her mother these techniques which she learned during session. "Emma" was also introduced to the method of progressive muscle relaxation, as well as "thought stopping." She reported that these techniques were useful when she had flashbacks of the abuse. "Emma" learned during treatment the importance of being able to identify emotions and eventually developed the ability to verbalize them.

Many children develop negative behaviors in order to cope with the negative feelings that are triggered by thoughts of the sexual abuse. Therefore, it is crucial that these children are given alternative methods to work through these feelings. Developing a Trauma Narrative is one strategy to work through these feelings. (Judith A. Cohen, M.D., Esther Deblinger, Ph.D., and Anthony Mannarino, Ph.D, 2006). Initially, "Emma" was resistant in writing the details of the event, however, she utilized the skills she had learned throughout the course of treatment in order to reduce the anxiety. The goal is to reduce the impact of experiencing negative emotions when thoughts of the abuse arise (Judith A. Cohen, M.D., Esther Deblinger, Ph.D., and Anthony Mannarino, Ph.D. 2006). "Emma" shared her story of abuse in writing during therapy, and eventually with her mother. She verbalized a sense of well being in the weeks following the trauma narrative. She is now able to communicate openly about her history of sexual abuse.

"Tracy" was an eight year old youngster when she began treatment at South Shore Child Guidance Center due to being sexually abused by a family member. "Tracy" suffered from flashbacks due to the abuse. She suffered from depressive symptoms, anxiety, and insomnia. Once "Tracy" mastered the stress management techniques learned in Trauma Focused Cognitive Behavioral Therapy she showed a major improvement in her level of functioning. She was able to write the trauma narrative and verbalize her feelings without experiencing severe anxiety. She suffered from shame and blamed herself for the cause of the trauma. These issues were explored during the course of treatment through the method of cognitive processing. Cognitive processing works to challenge false or unhealthy cognitions. (i.e. "I am a bad person") (Judith A. Cohen, M.D., Esther Deblinger, Ph.D., and Anthony Mannarino, Ph.D. 2006). "Tracy" was able to develop a more positive self image, and maintain healthy relationships in treatment. She graduated high school, and is attending college. Although she remembers the sexual trauma, she is no longer paralyzed by her negative emotions associated with it.

"Danielle" was referred for therapy due to suffering from sexual abuse from her grandfather. Danielle was six years old at the time of abuse. "Danielle" was manifesting symptoms of highly sexualized behavior, impulsivity, as well as Post Traumatic Stress Disorder. According to the family, "Danielle" was known as a bully towards other children, and did not have any friends. While learning the technique of affect expression and modulation, "Danielle" developed ways to identify her feelings and express them more appropriately (Judith A. Cohen, M.D., Esther Deblinger, Ph.D., and Anthony Mannarino, Ph.D. 2006). Throughout the course of treatment, "Danielle" began to demonstrate more appropriate behaviors with her peers at school. She was invited to a birthday party for a friend in class. Her parents were able to experience positive family functions. "Danielle" is currently doing well at home and at school and is no longer engaging in acting out behavior. Throughout the course of treatment at South Shore Child Guidance Center, "Danielle" has learned techniques in order to prevent re-victimization of sexual abuse. She has also learned the skills necessary to develop healthy relationships with her peers at home and at school.

While CBT is a wonderful treatment modality for trauma resolution, we continue to learn about effective treatments for Traumatic Stress Disorder. All additional traumas are certainly complex as are people's adaptation to traumatic life experiences. It is hoped that we continue to recognize treatment approaches such as this modality and other approaches that can help integrate traumatic experiences so that survivors see themselves as capable and worthy of healing from the past.

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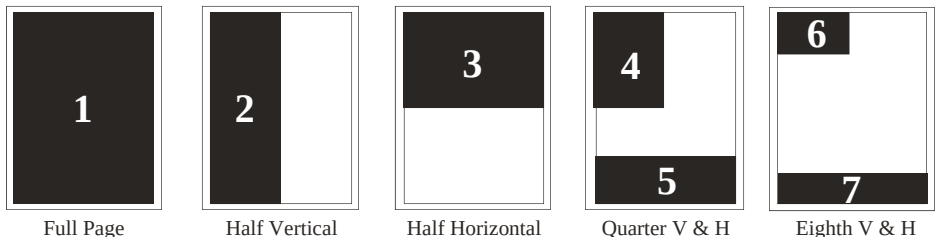

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