MENTAL HEALTH NEWS™

YOUR TRUSTED SOURCE OF INFORMATION, EDUCATION, ADVOCACY AND RESOURCES

WINTER 2013 FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE VOL. 15 NO. 1

Understanding and Treating Posttraumatic Stress Disorder

PTSD and Secondary Traumatization: A Comprehensive Review

By Robert W. Motta, PhD, ABPP
Professor and Director of the Doctoral Program in School and Community Psychology at Hofstra University

Robert W. Motta, PhD, ABPP

Posttraumatic stress disorder (PTSD) is a reaction to life threatening events and to extremely frightening situations in general. Those who are interested in knowing about PTSD often consult diagnostic manuals and encounter a menu of symptoms such as sleeplessness, flashbacks, intrusive thoughts, etc. While these symptoms describe characteristics of PTSD they do not give a feel for the true nature of this disorder. PTSD essentially involves a transformation of the self, which can occur following extremely frightening situations. It is far more than a listing of symptoms. Traumatized people find that they are different from their pre-trauma selves.

Those who are traumatized often feel a sense of alienation from themselves and others. They have a fairly negative view of themselves and lack a sense of optimism that things eventually will work out. They have lost many of their prior positive expectancies such as the belief that hard work leads to success or that right will eventually win out over wrong. Their foundational perspectives of themselves and the world have been altered as a result of having encountered horrifically fear-producing events and they no longer believe that the world they once knew is a valid one. The resulting view of themselves, others, and the future are decidedly negative due to having encountered events that were well beyond what they might have expected. Traumatized individuals often do not recognize and do not like the negative, suspicious, and distrustful person they have become. Having been severely traumatized, they now view their world with doubt and wariness. PTSD is an optimism-crushing disorder.

Epidemiology: PTSD is not the inevitable outcome for those who have been traumatized. In fact, fewer than 10 percent of individuals who have encountered stressors such as those that meet criteria set in the Diagnostic and Statistical Manual of Mental Disorders (DSM) actually develop full PTSD (Breslau, 2009). Approximately seven percent of individuals have PTSD in the general population and 19 percent of Vietnam theater veterans are current PTSD cases (Dohrenwend et al., 2006). In situations of intense combat these PTSD rates increase significantly. Nearly one in four (24.5 %) of Iraq and Afghanistan war veterans have received a PTSD diagnosis by the Veterans Health Administration (VHA Office of Public Health and Environmental Hazards, 2009). Terrorized communities in Cambodia during the era of the Khmer Rouge rampage had responses that matched the symptoms of PTSD in virtually 100 percent of those samples, but after three years the rate in youngsters was 50% (Kinzie, Sack, Angell, Clark, and Ben, 1986). In a study of sexually abused foster care children, PTSD rates exceeded 60 percent (Dubner and Motta, 1999).

In terms of demographics, females generally develop PTSD at a higher rate than males. In addition, the younger one is and the more one has preexisting psychological

see Review on page 6

Virtually Endless Possibilities in Trauma-Related Mental Health Care: A New NYC-DOHMH Training Initiative

By Monika Erős-Sarnyai, MD, MA
Best Practices Specialist
New York City Department of Health and Mental Hygiene

We are at a turning point in the way we teach and learn medicine. In this information age, virtual technology-based training methods are becoming powerful learning tools for medical professionals, allowing them to learn and practice new skills, anytime, anywhere: from their homes, offices or from remote locations, as their schedules permit. These trainings are designed to capture interest, enhance learning, and encourage retention of information through active participation.

Embracing these new computer-based technologies and responding to the changing training needs of health care professionals, the New York City DOHMH in collaboration with Kognito Interactive (www.kognito.com) is developing two online interactive trainings (Winter 2012) designed to promote behavioral changes and thereby increase providers' ability to manage the acute and long term mental health conditions most commonly associated with trauma exposure.

The trainings will utilize Kognito's proprietary and award-winning simulation platform (previously tested with emergency room physicians and returning military veterans and their families) to create virtual role-play conversations with avatars who are intelligent, fully animated, and emotionally responsive. Key information and practical strategies will be presented through the use of narrative "case-examples," role-play situations and high levels of interactivity. By embracing this new method of training and professional learning, the DOHMH hopes to better accommodate health care professionals' needs, training preferences and busy schedules, offering a custom training program.

The first training is focused on providing integrated disaster and other trauma related care in primary care settings, and the second on exposure therapy for PTSD (both trainings are further described below). Each training is approximately 90 minutes long and broken into modules of 20 minutes or less to allow providers to take the course all at once or module-by-module, as time permits.

In addition to adopting an emerging new technology with the key advantages of allowing learners to practice and master new skills in a safe, simulated environment and revisit cases as needed; these two trainings also aim to address a critical need for enhancing the healthcare system's capability to better address the mental health needs of populations exposed to trauma. While the majority of people exposed to disasters and other traumatic events will recover, others will find coping with what they experienced or witnessed more difficult, and without help they may develop trauma-related mental health disorders. As many who would benefit from getting professional support are reluctant to seek help and those who do seek support often find the system-of-care challenging to navigate, these trainings are designed to improve the identification and management of trauma related mental health needs and thus, foster recovery and better outcomes.

see Training on page 12

NON PROFIT
ORGANIZATION
U.S. POSTAGE PAID
MONROE, CT
PERMIT NO. 137

Mental Health News Education, Inc.
460 Cascade Drive
Effort, PA 18330

Mental Health News Education, Inc. Board of Directors

Mental Health News Thanks Our Sponsors for their Support

Platinum Sponsor

Nassau County Department of Mental Health
Chemical Dependency and Developmental Disabilities

New York City Department of Health and Mental Hygiene

New York State Office of Mental Health

Westchester County Department
of Community Mental Health

Silver Sponsor

The Bridge

F·E·G·S Health and Human Services System

Four Winds Hospital

Services for the Underserved

Help Support Our Nonprofit Mission Become an Honored Sponsor of Mental Health News Education, Inc.

Benefactor Sponsor: $25,000

Benefactor Sponsors will receive two full page advertisements and article space in 4 quarterly issues of either Mental Health News or Autism Spectrum News. They will also receive multiple bundles of newspapers as needed for distribution to clients, staff, board members, and satellite programs.

Platinum Sponsor: $10,000

Platinum Sponsors will receive one full page advertisement and article space in 4 quarterly issues of either Mental Health News or Autism Spectrum News. They will also receive multiple bundles of newspapers as needed for distribution to clients, staff, board members, and satellite programs.

Gold Sponsor: $5,000

Gold Sponsors will receive one half page advertisement and article space in 4 quarterly issues of either Mental Health News or Autism Spectrum News. They will also receive several bundles of newspapers for distribution to clients, staff, board members and satellite programs.

Silver Sponsor: $2,500

Silver Sponsors will receive one quarter page advertisement in 4 quarterly issues of either Mental Health News or Autism Spectrum News. They will also receive one bundle (50 copies) of newspapers for distribution to clients, staff, board members, and satellite programs.

Bronze Sponsor: $1,000

Advisor Sponsor: $500

Friend Sponsor: $250

All Sponsors will receive recognition listing on our honor roll page in either Mental Health News or Autism Spectrum News

To Discuss our Sponsorship Opportunities Please Contact

Ira H. Minot, LMSW, Executive Director
Mental Health News Education, Inc.
460 Cascade Drive, Effort, Pennsylvania 18330
E-mail: iraminot@mhnews.org Phone: (570) 629-5960

Table of Contents

Mental Health News
2013/2014 Theme and Deadline Calendar

Spring 2013 Issue:

"Moving the Mental Health System Towards
a Person Centered, Recovery Oriented Approach "

Deadline: January 23, 2013

Summer 2013 Issue:

"Mind Over Body: Understanding and Treating Eating Disorders"

Deadline: April 23, 2013

Fall 2013 Issue:

"Housing and Employment: How Are We Doing?"

Deadline: July 23, 2013

Winter 2014 Issue:

"Living With Emotional and Physical Pain"

Deadline: October 23, 2013

To Submit an Article or Advertisement

Call Us Today: (570) 629-5960

Or Email: iraminot@mhnews.org

Mental Health News™

Is a Publication of Mental Health News Education, Inc, A Nonprofit Organization.
Mailing Address: 460 Cascade Drive, Effort, PA 18330
Phone: (570) 629-5960 E-mail: iraminot@mhnews.org Website: www.mhnews.org

Integrative Treatment for Co-Occurring Disorders in Service Members, Veterans, and Military Families in a Civilian Inpatient Setting

By Michael DeFalco, PsyD and Tara Bulin, LMSW Holliswood Hospital

Since September 11th, 2001, over two million United States service members have been deployed to Iraq and Afghanistan. Multiple factors related to the conflicts in Iraq and Afghanistan and the Global War on Terror (e.g., multiple deployments, length of deployments, intensity and nature of combat operations) have led to an increase in psychological disturbance among service members following their deployments (Rand Study, 2008). Behavioral health issues such as posttraumatic stress disorder (PTSD), depression, traumatic brain injury (TBI), and substance misuse have been seen at increasing higher rates not only in active-duty service members, but in our veteran population as well. Obviously, these problems do not end when an individual separates from the military, but the onus of responsibility for who is responsible for their care does. This shift in responsibility does not fall solely on the Veterans Administration (VA); it also falls on civilian providers of healthcare in the community. President Obama's signing of an Executive Order to improve access to mental heath services for veterans, service members, and military families on August 31, 2012 highlights how these issues have been recognized at the highest levels of government, and that a change in national strategy is needed to meet the needs of our military that have been identified and continue to be unmet. Part of President Obama's multi-pronged approach asks for partnerships between the VA and community providers to enhance access to mental health care. President Obama has also called for focused attention on treatment- specifically research on treatments for PTSD and TBI (White House Press Release, August 31, 2012). There is a recognition that both within and outside of the VA it can be difficult to identify treatments that work as well as individuals who are competent to provide such treatments.

Examining these challenges for our service members, veterans, and military families on a more local level, the RAND Corporation conducted A Needs Assessment of New York State Veterans in 2011. Sponsored by the New York State Health Foundation, this study found that, among New York State veterans, a significant proportion of those surveyed (56%) were identified as having a need for mental health services. Despite this need, only about half of those individuals actually sought care in the prior year. Most concerning for the half who sought services is that only half received or completed a "minimally adequate" course of treatment. Regarding preference for where veterans want to go for care, 46% indicated they would prefer to receive mental heath services from a civilian provider (as opposed to the VA).

These realities highlight a number of factors that civilian, community providers of mental health services need to consider. First, a provider may choose not to take part, or have the opportunity to take part in, the care of active-duty service members and their families. However, they cannot ignore the fact that veterans and their families live within our communities, and some will be in need of competent treatments for PTSD, depression, substance misuse, and other behavioral health issues. To that end, we call have a civic duty to understand the culture from which our veterans come (i.e., military culture), to learn about the range of mental health issues our veterans and their families may be dealing with, and to either provide sound treatments for them or be part of a service-delivery network where we can refer them to if they come through our doors.

For some service members and veterans, the result of their experiences while serving (e.g., combat trauma) leave them with such acute and severe issues that they require an inpatient level of care to be treated in a safe and focused way. While in an inpatient setting, service members may have the opportunity to not only receive medication that will facilitate the stabilization of mood and behavioral symptoms, but also to receive intensive, trauma-specific therapies that assist in the promotion of recovery from both trauma and substance/alcohol abuse. In our Military Wellness Program at Holliswood Hospital, we have developed an integrative model of inpatient treatment for behavioral health and substance misuse disorders, based on five integrative domains: 1) Integration of trauma treatment and substance/alcohol abuse treatment; 2) integration of developmental trauma theory and acute/situational trauma theory; 3) the integration/ assimilation of traumatic memories into existing memory networks; 4) integrating family members into the fabric of treatment for wounded warriors, focusing on enhancing family resiliency and recovery, and 5) integrating a "traditional" inpatient treatment program with trauma processing treatments (i.e.- exposure therapy), expressive arts therapies, alternative treatment approaches (acupuncture and yoga) and the promotion of peer support. What follows is a brief overview of each domain and the application of such a domain in the treatment of service members.

Domain One - Integration of trauma treatment and substance/alcohol abuse treatment: When one develops the knowledge and understanding of the relationship between trauma and substance/alcohol use, the integration of trauma treatment and substance/abuse treatment is truly the only logical model of treatment to follow. Fisher (2000) most succinctly elucidates a coalescence of both trauma and substance/ alcohol use- she refers to the use of substances as a "survival strategy" when one is confronted with or exposed to triggers or reminders of the traumatic memory; a way for the individual to allay themselves of overwhelmingly unmanageable and destructive thoughts and dysregulated feelings. Her work, based partly on that of Siegal (1999), refers to each individuals "Window of Tolerance," whereas their ability to maintain the self within the window of tolerance allows for manageability and control over thoughts and/or emotions. Once outside this zone of optimal arousal, thoughts and feelings become overwhelming, leaving the traumatized individual at increased risk to self-medicate with either substances and/or alcohol. Persons exposed to overwhelming trauma or suffering from posttraumatic stress disorder show a "bi-phasic" trauma response, vacillating between emotional and behavioral "highs" (e.g., hypervigilance, agitation, obsessional thinking) and lows (extreme dissociative states, lethargy, depression) and have difficulties with emotional regulation. Teaching service members this concept (the relationship between emotional dsyregulation and substance misuse), and teaching them more adaptive ways to regulate their emotional and physiological arousal, is a key aspect of treatment.

Domain Two - Integration of developmental trauma theory and acute/ situational trauma theory: Integrative inpatient treatment of PTSD and substance misuse disorders requires an intimate understanding of the difference between developmental trauma, (as defined by van der Kolk and colleagues) and what we think of as acute (or adult-onset) trauma; as well as the interface between the two. van der Kolk (2005) defines developmental trauma as a chronic exposure to trauma, typically experienced during childhood (e.g. – childhood physical and/ or sexual abuse), and of an interpersonal nature that impedes the development of the child's ego in such a way that leaves them at increased risk for subsequent trauma (and difficulties managing that trauma) over the lifespan. Furthermore, exposure to trauma of this nature almost always leads to impairments in the following domains of functioning: biological, cognitive, attachment, affect regulation, self concept, dissociation, and behavioral control (for a more extensive description, please see Cook, Spinazzola, Ford, Lanktree, et al., 2005; van der Kolk et al., 2009). Acute trauma, or what we have come to know of as PTSD, as defined in the DSMIV-TR recognizes that a single event (e.g. car accident) or even sometimes multiple events experienced as an adult impact the psyche in a negative way. However, while exposure to an acute traumatic event may negatively impact the emotional and behavioral functioning of an individual, it does not necessarily alter the developmental trajectory of an individual or present it's sequela in as pervasive or diffuse a manner as seen with developmental trauma. For example, the three main criteria for PTSD (re-experiencing, avoidance and numbing, hyperarousal) are much more focal and directly tied in both content and experience to the actual traumatic event when compared with the sequela of developmental, interpersonal trauma experienced during childhood and adolescence. When working with service members who have been exposed to trauma, it is important to inquire not only about combat or deployment-related trauma, but also a history of developmental trauma. Only after one gains a comprehensive overview of the service member's lived experience can the treatment provider proceed with the appropriate course of treatment that can account for multiple levels of traumatic exposure and their interactions.

Domain Three - Integration of traumatic memories into existing memory networks: A major part of integrative treatments aimed at decreasing the frequency and severity of trauma triggers experienced by service members (and also aimed at decreasing their vulnerability for substance misuse) is to facilitate the integration of split-off traumatic memory traces (e.g., affect states, body sensations, image fragments, etc) back into declarative, narrative memory networks so that they are more in the volitional control of the service member and carry less intensity over time. In addition, the "paired associations" that have been classically conditioned around traumatic experiences must be desensitized to likewise reduce trauma triggering and emotional/ physiological reactivity. These associations,

see Considerations on page 33

PTSD Among Veterans: A Signature Wound that Desperately Needs Healing

By Kimberly Williams, LMSW and Jason Hansman MHA of New York City

Veterans returning to civilian life from Iraq and Afghanistan are suffering from tragically high rates of mental and substance use disorders. Post-traumatic stress disorder (PTSD) has become a hallmark injury among returning veterans, with a prevalence rate of approximately 20 percent—a rate two to three times the general population. Overwhelmed by flashbacks, nightmares, increased arousal, startling easily, and difficulty sleeping, returning service members with these symptoms experience significant challenges reintegrating back into civilian life. This issue is coupled with a staggering suicide rate; the Veterans Affairs Department estimates that a veteran dies by suicide *every 80 minutes*. And the magnitude of this issue is all the more urgent with more troops coming home.

Higher rates of PTSD are associated with these more recent wars due to longer deployments, multiple deployments, and a greater time away from base camp. Among returning soldiers, PTSD isoften associated with co-occurring disorders, such as depression, substance abuse problems, and traumatic brain injury (TBI), complicating diagnosis and treatment. For instance, PTSD and TBI, which are both signature problems among returning veterans, have similar, overlapping symptoms, which professionals are often challenged in differentiating. Veterans with PTSD are also more likely to experience psychosocial challenges such as relationship problems, violence, unemployment, homelessness, and incarceration.

Family members are also suffering. The return home requires great adaptation, particularly in supporting a veteran with a behavioral health need. Children of veterans with PTSD are at risk of experiencing secondary traumatization (PTSD symptoms related to witnessing their parent's symptoms) as well as at greater risk for academic, behavioral, and interpersonal problems.

Many veterans and family members need help in dealing with these challenges. Unfortunately, only half of returning veterans with PTSD receive treatment. Significant barriers exist in seeking and accessing appropriate care. Many veterans do not seek mental health services for reasons of stigma, fear of the impact it will have on their careers, lack of information about available resources, distance to a VA facility, lack of eligibility for VA services and finding the system too difficult and time consuming to navigate.

The VA, known for state-of-the-art services, has made significant strides in recent years to address this problem by launching the Veterans Crisis Line (800-273-TALK, Press 1), and increasing its mental health service capacity, both of which have been expanded under President Obama's recent Executive Order.

However, the fact remains that only 55% of OIEF/OEF veterans have obtained VA health care.. Perhaps more would use the VA if the eligibility and access problems were addressed. But many veterans simply do not want to use the VA. According to the RAND needs assessment of New York State veterans, nearly half of veterans want to receive mental health care outside the VA system. Many prefer to return to civilian life and get care from primary care physicians or community clinics in their local communities.

Therefore, while the federal VA must continue to bolster its resources, it cannot bear the sole responsibility for caring for veterans with behavioral health needs. It is going to take concerted, focused, and coordinated efforts by all—the VA; other government agencies at the federal, state, and local levels; not-for-profits providers; and the private sector—to overcome this challenge.

This is why the Mental Health Association of New York City (MHA-NYC) and the Iraq and Afghanistan Veterans of America (IAVA) have joined forces to co-lead a Leadership Council for Veterans, Service Members, and Their Families (The Council). The Council is a high level advisory to the National Traumatic Brain Injury and Emotional Wellness Alliance, which was recently founded by MHA-NYC and is made up of a diverse cross section of prestigious, respected leaders from around the country who are dedicated to diligently confronting and collaborating to overcome the significant gaps in behavioral health care that veterans now face.

We are calling for:

- Expanded suicide prevention efforts
- Expanded access to mental health supports through more responsive and integrated services via the VA, other public, and private systems
- A larger and more competent behavioral health workforce both in the VA and in the civilian based system
- Enhanced public education and outreach efforts to combat stigma and to provide information about behavioral health issues and about where to get help
- Increased mental health supports for military families

By working together, we can expand our reach in advancing these recommendations. Implementation will require significant political will and resources, which will be difficult in a tight economy. But after risking their lives for our great nation, we owe our brave military heroes nothing less than the best possible care so they can successfully reintegrate into society and thrive as fellow civilians. We must ensure that every veteran gets the care they deserve.

Kimberly Williams, LMSW, Director, National TBI and Emotional Wellness Alliance, the Mental Health Association of New York City and Jason Hansman, Senior Program Manager, IAVA.

Review from page 1

problems, the greater the chance of developing this disorder. Despite the psychologically debilitating nature of PTSD, the majority of individuals who encounter significant stressors do not develop this disorder but may develop other problems such as anxiety reactions and depression. Those who are unfortunate enough to develop PTSD face a radically altered lifestyle.

Historical Roots: Reactions to trauma have been known and described for centuries. They were alluded to as far back as Homer's Iliad written 27 centuries ago. The Iliad contains many descriptions of soldiers, who, after combat, experienced nightmares, mental confusion, and sleeplessness. There are also historical literary heroes and heroines who displayed symptoms we would now see as PTSD, including in Shakespeare's Henry IV where one of the English combatants, Hotspur, in a war with the Scots subsequently experienced sleeplessness, nightmares, and a transformation to a more negative and somber individual. Shakespeare wrote Henry IV over 400 years before the 1980 DSM inclusion of PTSD (Trimble, 1985). Samuel Pepys diary in 1666 contains quotations of sleeping difficulty and night terrors in response to the Great Fire of London (Daly, 1983). During the American Civil War (1861-1865) trauma reactions were noted to occur in the absence of physical injury and these reactions included irritability, rapid heart rate, and increased arousal. The condition became known as DaCosta's Syndrome, named after the American physician who described them. The condition was also referred to as Soldiers Irritable Heart or Irritable Heart Syndrome, perhaps in reference to the belief that the elevated heart rate following combat was of organic etiology.

Emotional reactions mirroring symptoms of PTSD have occurred as a result of railway accidents during the uncertain development of our rail system. These responses became known as "railway spine" due to a belief that the trauma reactions had a neurological basis, (Trimble 1981). Terms such as "shell shock" and "combat neurosis" in WWI and WWII, and "rape trauma syndrome" in the 1970's are also descriptive of the symptoms of PTSD. However it was not until the publication of the Third Edition of the Diagnostic and Statistical Manual of Mental Disorders (3rd ed.; DSM-III; American Psychiatric Association [APA], 1980), that PTSD became an officially recognized disorder. The DSM III alluded to traumatic events that were "beyond the range of normal human experience." The Vietnam War was a driving force for the inclusion of PTSD in the DSM. The criterion that the trauma experience should be beyond the range of normal human encounters was subsequently dropped when it was found that relatively common stressors such as car accidents, life threatening illness, and child abuse could also precipitate PTSD.

Case Examples - Case #1: A young man goes off to war in the Middle East with a sense of excitement, patriotism, and belief that what he is doing is justified. He is helping to insure that people have freedom in their own countries just like they do in America. He may see the American way, while having its flaws, as a basically "right" system that guarantees personal liberty and a chance of betterment through effort. This young combatant then encounters the horrors of war, of killing, of death of friends, of dismemberment of young men just like himself, broken, bleeding, and crying out in pain. These experiences precipitate a stark alteration in his perceptions. His self-assurance is replaced by a realization that no matter what his training, no matter how skilled he thought he was, a roadside bomb, a sniper, or simply being at the wrong place at the wrong time will end his life or disable him. His earlier self-view is shattered.

Bravado is replaced by fear, and as he sees himself reacting as a frightened and vulnerable person, his self-view is shifted dramatically to the negative. He may begin to doubt much of what he has learned as a combatant and to question the motivations and goals of the country that sent him to what he now may view as an arena of indescribable chaos and suffering. The person he was when he went off to war differs radically from the person he has now become. He feels a sense of alienation from himself and his world. He feels old. He is no longer that optimistic young man. He is now a Veterans Administration patient receiving anti-depressant medications and psychotherapy for PTSD.

Case #2: A woman who has been brutally raped is, of course, ridden with anxiety, sadness, and distrust. She requires multiple assurances that things will work out and that, hopefully justice will be done. But for many women the consequence of rape runs far deeper than fear

see Review on page 14

Let's Not Forget Older Veterans

By Michael B. Friedman, LMSW
Mental Health Policy Advocate

Wilbur Cohen's account of his post-war suffering in Arthur Kleinman's wonderful book, *What Really Matters*[1] begins with the following: "The war. It's what happened to me in the war. I could never get over it. But I learned to live with it. Then all of a sudden on my sixtieth birthday it became a terrible weight. I couldn't put it out of mind. I feel so very depressed about it. Sometimes I sit for hours, brooding over the past."

Mr. Cohen had been in hand-to-hand combat in the Pacific theatre in World War II. After the war he had gone to college, become financially successful, and raised a family. Only after he had fulfilled his responsibilities as an adult did his profound sense of horror about the war return. Was it because he had time now to relive the past? Was it a symptom of major depressive disorder? Was it the recurrence of post-traumatic stress disorder? Was it because his cognitive abilities were on the decline and he could no longer hold off what he had kept buried in his unconscious for nearly 40 years? Whatever the cause, Mr. Cohen's experience as he aged is not unique.

For many veterans, old psychic wounds re-emerge as they age. But, older veterans with mental health needs have not received nearly as much attention as the men and women who have been deployed in the wars in Iraq and Afghanistan and returned with mental disorders.

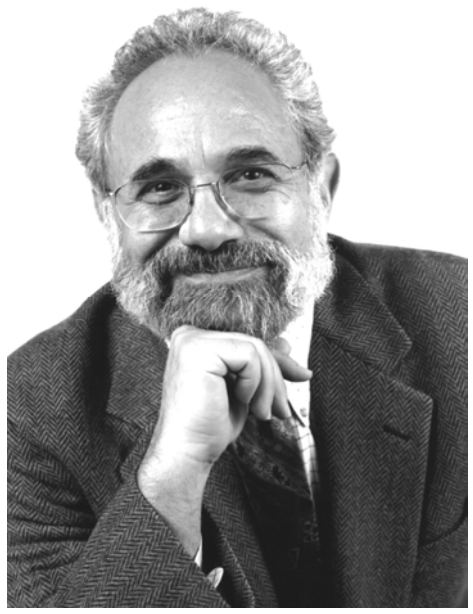
This is entirely understandable. Veterans of our nation's current wars often suffer terribly and deserve all the support that our nation can muster.

But the fact of the matter is that veterans of these recent wars make up only 10-15% of our nation's veterans. Currently, over 50% of veterans are 60 or older, and about 45% are 65 or older. Unfortunately, they too are a higher risk than the general population for mental disorders—including post-traumatic stress disorder (PTSD), which can continue for years or can re-occur in old age.

It is not my intention to pit veterans of prior periods of history against the veterans of the recent wars. But it is important to acknowledge that veterans of past periods also deserve our nation's concern. Here are some key facts:

· The Department of Veterans' Affairs (VA) projects that the current age distribution of veterans—roughly 45% aged 65 or over and roughly 55% 60 or older—will continue at least until 2035. During this period there will be a decline in the proportion of veterans from World War II and the Korean Conflict, but a very substantial increase in the proportion who are Vietnam veterans.[2]

· Most Vietnam Veterans are part of the elder boom now occurring in the United States and are affected by the mental health challenges that confront that generation. It is likely, however, that they have a higher prevalence of major depressive disorder, anxiety disorders such as



Michael B. Friedman, LMSW

PTSD, and even dementia than those who did not serve in the military. For example:

· "According to the VA's National Registry for Depression, 11% of Veterans aged 65 years and older have a diagnosis of major depressive disorder, a rate more than twice that found in the general population of adults aged 65 and older."[3]

· Nearly 40 percent of Veterans age 60 and over in treatment for depression also have a diagnosis of PTSD.[4]

· 12% of older veterans getting primary physical health care had symptoms of PTSD, according to a recent study.[5]

· "A study of Vietnam vets 20 years after the conflict found that a quarter of vets who served in Vietnam still had full or partial PTSD."[6]

· In 2011, "more than 476,000 veterans received treatment for PTSD from VA hospitals and clinics, up dramatically from about 272,000 in 2006. Iraq and Afghanistan veterans make up a large portion of that increase but still account for only about one-fifth of all PTSD patients. More than half of the new cases come from earlier wars."[7] (Emphasis added.)

· Aging veterans also face heightened risk of co-occurring mental and physical disorders. Obesity and high cholesterol, diabetes, and side effects of psychotropic medication are more common in individuals suffering from depression and PTSD, as are substance misuse, smoking, and poor health.[8]

· Older veterans are at high risk for suicide. It appears that older veterans complete suicide 50% more frequently than people of the same age who are not veterans.[9] A recent report claimed that in California, World War II-era veterans are taking their own lives at a rate that's nearly four times higher than that of people the same age with no military service.[10]

· Although the prevalence of dementia among veterans is roughly the same as that of the general population,[11] *the prevalence of dementia among veterans who have had PTSD may be as much as double the prevalence among those who have not had PTSD.*[12, 13, 14] It is unclear whether PTSD contributes to the development of dementia or if late onset PTSD is a consequence of dementia.

· Like all people disabled by dementia, veterans rely heavily on family members for care and support. And, like all family caregivers, *caregivers of veterans with dementia experience are at high risk of social isolation, depression, and anxiety*.[15]

In addition to being at risk for diagnosable mental disorders, older veterans are risk for **Late-Onset Stress Symptomatology (LOSS)**. According to the National Center on PTSD, "Many older Veterans have functioned well since their military experience. Then later in life, they begin to think more or become more emotional about their wartime experience. This process can trigger LOSS. People with LOSS might live most of their lives relatively well. … Then they begin to confront normal age-related changes such as retirement, loss of loved ones, and increased health problems. As they go through these stresses, they may start to have more feelings and thoughts about their military experiences."[16]

Treatment Works—When Used

Treatment of depression and other affective disorders as well as of anxiety disorders, including PTSD, is often effective. There is good evidence that it works for veterans as well as for people who have not had military experience. For example, a recent study indicates that older veterans with PTSD respond well to prolonged exposure therapy.[17]

In addition, new models of treatment are emerging for veterans. For example, VA researchers "are developing, testing and implementing new models of primary care to improve the outcomes among veterans affected by depression. Translating Initiatives for Depression into Effective Solutions (TIDES) is a model of care for veterans with depression that involves collaboration between primary care providers and mental health specialists with support from a depression-care manager. The program has shown impressive results with eight out of ten veterans effectively treated in three VA regions without the need for referrals to additional specialists."[18]

Unfortunately, even though treatment can be effective, a recent study of depression treatment of older adult veterans concluded: "**The odds of receiving depression treatment decreased with increasing age**. Many depressed older veterans may have limited or no treatment.[19]

VA Initiatives for Older Veterans

Over the past few years, the VA has significantly increased its efforts to respond to the mental health needs of veterans. In 2005 it promulgated a mental health strategic plan in which returning veterans from Iraq and Afghanistan were the greatest focus of concern. But older veterans have also benefited from efforts to prevent suicide, increase accessibility to treatment, to use evidence-based treatments, and to build delivery systems that integrate physical and behavioral health services.

More recently, an Executive Order, "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families", which was released in August of this year, dictates that the VA "establish pilot projects whereby the Department of Veterans Affairs contracts or develops formal arrangements with community based providers, such as community mental health clinics, community health centers, substance abuse treatment facilities, and rural health clinics, to test the effectiveness of community partnerships in helping to meet the mental health needs of veterans in a timely way."[20] Over time, this should substantially expand access to mental health care for veterans who live in communities where VA services are not readily available.

In addition, the VA has undertaken several initiatives that are specific to older veterans. In part, this is a continuation of the work done by the Geriatric Research, Education and Clinical Center (GRECC) that was established in the 1970s.[21] But there are also new initiatives that are an outgrowth of the VA's mental health strategic plan. One initiative specific to older adults involves "**integration of a full-time mental health provider** on…home-based primary care teams" to work with both veterans and their families. Another initiative is the integration of mental health providers into the VA's long-term care centers, which are now called "community living centers." Other settings in which mental health services are now included and reach many older veterans are hospice and palliative care settings, spinal cord injury centers, and rehabilitation centers for the blind.[22]

Promises to Keep: Criticism of VA Initiatives for Older Veterans

Although the VA has substantially stepped up its efforts to expand and improve mental health care for older veterans, it has been subject to considerable criticism from advocates for veterans such as Vietnam Veterans of America and Veterans for Common Sense.

Critics have noted, for example, that over the past five years the number of veterans seeking mental health services has grown by a third, and while the\ VA has increased services and staff, it has struggled to keep up with the demand….[23]

Critics have also pointed to a VA investigation revealing that the VA does not consistently live up to its policy requiring that "all first-time patients referred to or requesting mental health services receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days."[24] Veterans for Common Sense is now suing the VA over delays in treatment.

The VA Cannot Do It Alone

Even as the VA works to step up its efforts, as all agree it should, some

see Older Veterans on page 34

The Many Aspects of Posttraumatic Stress Disorder

By JoAnn Difede, PhD, Director, and Melissa Peskin, PhD, Postdoctoral Fellow, Program for Anxiety and Traumatic Stress Studies
Weill Cornell Medical College

Posttraumatic stress disorder (PTSD) is an anxiety disorder that may develop in individuals who have experienced or witnessed an event that involves threatened death or serious injury, such as military combat, physical or sexual assault, natural disaster, terrorist attack, or motor vehicle accident. When an individual is faced with such an event, the sympathetic nervous system, or "fight or flight" response is activated, which sends adrenaline rushing through the bloodstream and leads to elevated heart rate and increased blood flow to muscle groups to help the individual prepare to fight or flee the danger. Although this system is adaptive and can help the individual survive, the fight or flight response can quickly become associated with cues in the environment, such as sights, sounds, or smells that are present during the trauma. When the individual encounters these same cues at a later point in time, even though the immediate danger has passed, the fight or flight response is triggered again, and the body reacts as though it is in danger. For example, an Iraq war veteran who witnessed a vehicle get hit with an Improvised Explosive Device concealed under garbage on the side of the road may learn to associate piles of garbage with danger, so that later, when he is home, the sight of refuse by the roadside triggers memories of this event and activates his fight or flight response. PTSD symptoms are grouped into three clusters, including re-experiencing symptoms, such as the example described above, where memories of the event come back to the individual in several different ways, avoidance and numbing symptoms, where the individual tries to avoid reminders of the trauma or may feel emotionally numb, and hyperarousal symptoms, such as hypervigilance to potential dangers in the environment, irritability, and difficulties sleeping and concentrating.

Although the diagnosis of PTSD was not officially listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1980, the core features of the disorder have long been evident in soldiers returning from combat, described variously as "shell shock," "battle fatigue," or "soldier's heart." The inclusion of the disorder in DSM-III led to a burgeoning of research on its etiology, effects, underlying neurobiology, and effective treatment approaches. The return home of over 1.5 million U.S. service members from combat theaters in Iraq and Afghanistan has lent a new urgency to efforts to disseminate effective treatments to a wider number of practitioners, enhance the efficiency of existing treatments, and utilize telemental health applications to reach the broadest number of affected individuals, particularly those constrained by logistical or practical barriers to care. These efforts are particularly important given that current estimates suggest that one in five service members suffers from PTSD following deployment to Iraq or Afghanistan and the considerable costs of PTSD for individuals, families, communities, and society. These costs are not trivial, as studies have found that the development of PTSD following violence exposure (such as combat) is associated with joblessness, homelessness, substance use, and imprisonment.

A large body of research has shown that PTSD is associated with significant occupational, psychosocial, and medical impairments. The disorder negatively impacts functioning across domains, and can lead to absenteeism, lost productivity, inability to work, interpersonal relationship problems, intimate relationship distress, difficulties with emotional and physical intimacy, and increased risk of physical health problems, chronic diseases, and suicide. In addition to the toll PTSD exerts on the individual, one of the most devastating features of the disorder is the toll it takes on families. There are a number of different ways in which PTSD may adversely affect families. First, behavioral avoidance of trauma-related stimuli can make routine daily activities such as driving, shopping, socializing with friends, and participating in children's activities challenging. Often families attempt to accommodate the individual with PTSD by limiting involvement in activities, which can gradually circumscribe activities to the house. Second, the emotional numbing symptoms of PTSD, such as difficulty experiencing feelings of love or happiness, and feeling distant or cut off from others, can interfere with attachment to partners and children, emotional expression, communication, and intimacy. Finally, hyperarousal symptoms such as irritability are associated with increased conflicts, tension, and stress in close relationships.

Given the deleterious effects PTSD can have on families, it is fortunate that a multitude of studies have shown that cognitive behavioral therapies, particularly exposure therapies, are effective in decreasing PTSD symptoms. Indeed, expert treatment guidelines for PTSD published for the first time in 1999 recommended that cognitive behavioral treatment with exposure therapy should be the first-line therapy for PTSD. The more recent 2008 report on the treatment of PTSD by the Institute of Medicine determined that exposure therapy was the only treatment for PTSD with substantial empirical support to conclude its efficacy. In contrast, the Institute of Medicine report did not find the same level of evidence in support of any other treatment approach, including pharmacotherapy. Exposure therapy involves gradually confronting feared memories and situations that are not realistically dangerous but are avoided because they are associated with the trauma and thus trigger anxiety. Most exposure therapies involve imaginal exposure, in which the patient is guided in repeatedly recounting memories of the trauma in a safe environment in order to facilitate extinction learning, whereby the cued fear response to memories of the trauma is extinguished, and the patient is better able to distinguish between thinking and talking about the trauma and feeling as if it is recurring.

Despite compelling evidence for the efficacy of exposure therapy for PTSD, the nature of imaginal exposure, whereby patients are asked to repeatedly recount their most traumatic event to a therapist, presents a challenge for some patients given that avoidance of trauma related memories, thoughts, and cues are, by definition, part of the diagnostic criteria for the disorder. Thus, the majority of individuals with PTSD fail to seek treatment, some who seek treatment do not engage in the treatment, and others who profess willingness struggle to engage emotionally with the trauma memory. As studies suggest that lack of emotional engagement predicts poor treatment outcome, these patients often do not improve. Finding effective ways to motivate these patients and facilitate emotional engagement in therapy is thus critical.

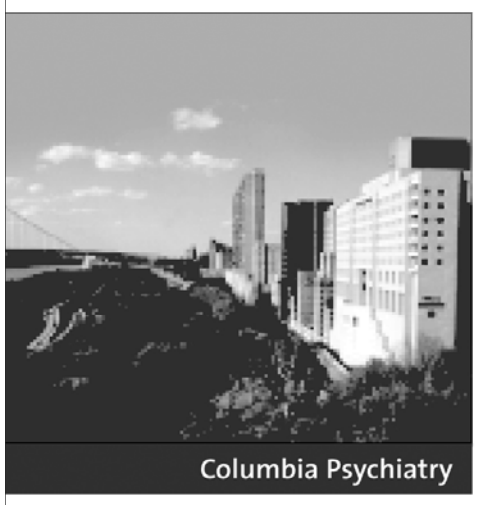
Fortunately, new developments in Virtual Reality technologies have expanded the range of possible treatment options for PTSD by drawing upon similar principles as imaginal exposure to reach patients who are reluctant or unable to recount their traumatic experiences using traditional imaginal exposure. Virtual Reality exposure therapy for PTSD provides a sensory-rich computer generated environment in which patients are able to encounter and gain mastery of their trauma. Patients gradually proceed through increasingly detailed virtual simulations of their traumatic event that are closely monitored by the therapist, while recounting details of their experience aloud. By allowing the therapist to program the virtual environment to control what the patient experiences, treatment can be tailored to the needs of the individual patient, and proceed at a pace that it tolerable for that individual. Moreover, Virtual Reality therapy can promote emotional engagement and processing of the trauma memory by offering not only visual, but auditory, olfactory and haptic sensory cues to facilitate immersion in the Virtual World.

Despite the success of Virtual Reality and other exposure therapies for PTSD, a number of barriers to treatment remain. First, misinterpretation of responses to trauma can occur when trauma survivors misattribute difficulties stemming from the trauma to causes that seem more routine or readily apparent. For instance, it may be less emotionally painful for an individual to conclude he is no longer in love with his wife than to remain in a marriage that is a constant reminder of his pre-trauma existence. Alternatively, parents may separate after losing a child partly because remaining together is an ongoing reminder of that loss; in this regard separation may constitute a form of avoidance. Such misattributions of trauma-related problems may be compounded by the failure of survivors and non-psychiatric providers to differentiate between a contextually "normal" level of distress" following a trauma and the development of PTSD symptoms that may benefit from specialist care. Furthermore, even when symptoms of PTSD are recognized and diagnosed, lack of dissemination and implementation of empirically validated treatments among mental health professionals may prevent survivors from receiving appropriate and efficacious treatment. Despite the overwhelming evidence in support of exposure therapy, studies have shown that unfamiliarity with evidence based treatments, inadequate training, and discomfort using exposure techniques are obstacles to clinicians' use of exposure therapy. These barriers may prevent individuals with PTSD from receiving optimal care.

In addition to barriers such as these, feelings of shame and concerns about stigma may discourage survivors from seeking treatment. For example, studies among military service members have found that treatment seeking for psychological problems may be inhibited by fears of negative perceptions, being considered weak, or damaging one's career. Fear of stigma and other treatment barriers may be particularly relevant to those most in need of treatment, as one study found that those Iraq and Afghanistan veterans who met screening criteria for a psychiatric disorder were more likely than those who did not to report such fears. Some studies suggest that perceived stigma may also be a particular concern for certain populations, such as ethnic or minority groups, who may be less likely to enroll in and attend PTSD treatment.

see Many Aspects on page 32

NEWYORK-PRESBYTERIAN PSYCHIATRY


Columbia Psychiatry


Weill Cornell Psychiatry/Manhattan


Weill Cornell Psychiatry/Westchester

To make a referral or for further information, please call:

Columbia Psychiatry
(212) 305-6001

Weill Cornell Psychiatry
(888) 694-5700

NewYork-Presbyterian Psychiatry provides a full continuum of expert diagnosis and treatment services for adults, adolescents and children with psychiatric, behavioral and emotional problems.

Accomplished specialists in psychiatry, psychopharmacology, clinical psychology and neurology work together to provide the highest quality of care, incorporating the most recent clinical and scientific advances. With proper diagnosis and treatment, virtually every mental health condition can be effectively addressed. We offer comprehensive and professional treatment in both inpatient and outpatient settings.

NewYork-Presbyterian Psychiatry delivers the best psychiatric care in New York and for 2011-2012 is ranked among the top five hospitals in the United States for psychiatry, according to *U.S. News & World Report®*.

BEST HOSPITALS U.S.News & WORLD REPORT HONOR ROLL 2011-12

NewYork-Presbyterian Hospital, created through the merger of New York Hospital and The Presbyterian Hospital benefits from the collaboration of two extraordinary programs, offering the highest level of psychiatric services by experts who are recognized leaders in their respective specialties. NewYork-Presbyterian Hospital's Behavioral Health program is consistently ranked among the nation's best, and is considered a premier program in the New York metropolitan area.

Columbia Psychiatry

NewYork-Presbyterian Hospital/
Columbia University Medical Center
622 West 168th Street
New York, NY 10032
212-305-6001

The Allen Hospital
5141 Broadway
New York, NY 10034
212-305-6001

Affiliate

New York State
Psychiatric Institute
1051 Riverside Drive
New York, NY 10032
212-543-5000

Weill Cornell Psychiatry

NewYork-Presbyterian Hospital/
Weill Cornell Medical Center
525 East 68th Street
New York, NY 10065
888-694-5700

NewYork-Presbyterian Hospital/
The Westchester Division
21 Bloomingdale Road
White Plains, NY 10605
888-694-5700

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

www.nyp.org/psychiatry

Training from page 1

Primary Care Providers:
Often the First Point of Contact for
Mental Health Care

Primary care settings are often the first point of contact for individuals seeking medical care, including those with mental health conditions. Yet, according to the SAMHSA Mental Health 2010 Study, a significant proportion of adults (62.1% or an estimated 27.9 million people) with mental illness go untreated.

Patients who experienced a traumatic event, such as a terrorist attack or violence or sexual assault, may seek treatment for their physical ailments from their primary care provider (PCP). At that time, they may also present with symptoms, or seek treatment for, trauma-related mental health conditions such as PTSD, depression, alcohol or substance abuse, and GAD. Primary care providers are in a key position to recognize symptoms and risk factors for trauma related mental health disorders, identify at-risk patients, and discuss treatment options with patients whose symptoms might otherwise go unnoticed and untreated.

By developing this training, DOHMH aims to supports PCPs in this key role. The training will support the provision of more effective and integrated mental health care by increasing PCPs' awareness of and knowledge about managing trauma related mental health disorders in their settings.

The training recognizes and provides strategies to overcome the main obstacles PCPs face when providing trauma related mental health care. Many PCPs view physical and mental health as separate and parallel tracks in healthcare provision and the majority have limited formal training about risk factors, symptoms and treatment options for mental health disorders. This lack of knowledge can impact the PCPs' ability to identify, treat or refer patients who may be at risk for, or already suffer from, trauma related mental health conditions.

Those PCPs who do provide treatment often turn to pharmacotherapy, overlooking evidence-based psychotherapeutic approaches; PCPs prescribe over 75% of all anti-depressants. (Wintersteen and West: Hylan et al, 1998). Consequently, the training aims to increase PCPs' knowledge about the symptoms, risk factors and treatment options for PTSD, depression, alcohol and substance abuse, and GAD, so that they can better recognize and identify these mental health issues in their patients. Through interaction with virtual patient avatars, PCPs will learn to navigate patient questions, concerns and potential resistance, thereby building skills for conversing with patients about potentially sensitive issues in a non-threatening, efficient and professional manner.

Another obstacle that PCPs face is time management related to the high volume of patients they see and the time required to thoroughly assess patients who may be at risk for developing trauma related mental health disorders. The training is designed to help PCPs to recognize that investing time initially with their patients can reduce the number of return visits, and can increase the chance of a better long-term treatment outcomes.

The training will also focus on the

Monika Erős-Sarnyai, MD, MA

importance of providing adequate follow-up care for patients recognized as at risk for PTSD, depression, alcohol or substance abuse, and GAD. It will offer exercises for effectively encouraging patient treatment adherence to help PCPs build skills that will support compliance with essential follow-up care. Finally, the training will address PCPs' concerns about their legal responsibilities when it comes to mental health treatment by emphasizing the importance of forming mutually beneficial partnerships with their mental health colleagues for consultation, and, if appropriate, referral of patients seeking care for trauma-related issues.

Embracing Exposure Therapy

According to the American Psychological Association (2008) traumatic events are those that threaten injury or death, while also causing shock, and feelings of terror or helplessness.With over two thirds of the general population experiencing a significant traumatic event at some point in their lives, and up to one fifth of the US population in any given year; traumatic experiences are relatively common. Post-traumatic stress disorder (PTSD) is one of the most common, and most widely studied mental health disorders, linked to trauma exposure. (Galea,2005). Almost 8 % of adult Americans experience PTSD at some point in their lives (C. Kessler ,National Comorbidity Survey Report, 2005).

Most individuals who develop PTSD find it very difficult to process their experience and cope with the memory of the trauma. As a result, even many years after the event, situations, objects, sounds, even smells can serve as "triggers" evoking bad memories, and causing the person to "re-live" their traumatic experience. Fearing these highly distressing memories, survivors with PTSD try to avoid such environmental "triggers" and may withdraw from activities they once enjoyed and distance themselves from friends and family.

Exposure therapy has a demonstrable effect in treating PTSD and other anxiety disorders. It is a form of cognitive behavioral therapy (CBT) which encourages individuals to confront their memories of the traumatizing events. In a meta-analytic journal article that included 13 studies, Foa et al. (2007) found that,

see Training on page 24

Looking Beyond PTSD: Are We Ready for Our Returning Heroes?

By Adriana Rodriguez, LCSW, Coordinator and Master Trainer, Home Again: Veterans and Families Initiative, Martha K. Selig Educational Institute, JBFCS

With an estimated 30,000 troops expected home from Afghanistan next month, the question that must be asked is: "Is the United States ready to accept these veterans back into society? Is it ready to help them reacclimate, resocialize, and reintegrate?" The answer is not a simple yes or no. To get to an answer, we must look deeply at job searches, VA benefits, diagnosing PTSD, and cultural competency.

Many of our returning soldiers will come home as veterans whereas others will continue to fulfill their service in the military. There are more than 40,000 nonprofit organizations in the United States with stated missions that focus on the needs of service members, veterans, and their families (Urban Institute, 2012). But do those nonprofits truly understand how the longest two-war cycles in America history has impacted this generation of veterans?

Recent studies have shown that many veterans will experience trauma due to the rigors and pressures of combat experience. But here's the rub: Not all veterans who have experienced combat trauma will be diagnosed with PTSD. The RAND Corporation's Center for Military Health Policy Research recently published findings from a study it conducted with veterans from Operation Enduring Freedom and Operation Iraqi Freedom and they found that one-third of veterans were currently affected by either PTSD or depression or have reported exposure to a traumatic brain injury. What's more, about 5 percent of OEF/OIF veterans had all three. RAND also found that only half of those who reported symptoms of major depression or PTSD had sought any treatment in the past year.

Readers may look at the one-third statistic and be awed. But it's important to highlight the proportion of veterans experiencing mental health problems because it demonstrates that not all veterans come home "broken." A large number of veterans, two -thirds of them to be exact, are ready to reenter the workforce or are eager to finish their education. They are waiting to reintegrate into the civilian world and explore new roles. But the question remains—are we ready for them?

An important variable that needs to be factored into this discussion is stigma and its impact on accessing services. In a recent op-ed in the *New York Times* ("Returning From War to a Check-up Full of Holes," October 9, 2012), Thomas J. Brennan, a sergeant in the Marine Corps, described the distant and casual demeanor a mental health professional exhibited when assessing him for thoughts of suicidal ideation while implementing the Department of Defense's mandatory Post Deployment Health Assessment. He notes: *"Her impersonal demeanor allows me to maintain a facade. A simple 'no 'suffices, and she moves to the next question. I think to myself, 'How easy this is?' One word moves us to the next topic. No red flags."*

At Home Again, where we train providers and employers in a culturally sensitive way of working with veterans, we've heard this story countless times from veterans who describe their reluctance to share their military experience because of the stereotypes and preconceived notions people have when you say you're a veteran. As Brennan also states: "The stigma made me nervous; I was concerned about being shunned if I got help for the feelings I had inside." In order to best treat and meet the needs of this generation of veterans, providers, nonprofits, and the like must equip themselves with accurate information and immerse themselves in the culture and literature of the military to dispel biases and decrease stigma.

One of the primary distinctions that needs to be understood is prevalence of trauma and whether experiencing trauma leads to a diagnosis of PTSD. We have learned that going into combat doesn't automatically lead to being exposed to trauma. Nor does being exposed to trauma lead absolutely to PTSD. Veterans are individual people and not everyone reacts the same way to similar experiences. If providers assume that all returning troops have PTSD, they will be promoting the myth of the "broken" veteran, which in turn leads to further stigma and will likely negatively impact the reintegration process.

With these ideas in mind, we can then focus on the values military culture instills. Military culture is considered collective where the needs and goals of the group come before the individual. Providers need to have a clearer picture of military culture and its effect on veterans before they can begin to serve them appropriately. Providers need accurate information as well as engagement strategies. Providers need to know what question to ask veterans, such as, "Why did you join the military? What branch did you serve in? Why did you join that branch? What was your MOS (military occupations specialty, aka job)? Did you deploy, if so where and for how long?" Asking the right questions demonstrates curiosity and a willingness to partner with the veterans and get a better sense of their experience and expertise in their own life before asking some of the heavier question such as a "Have you ever thought of hurting yourself?"

At Home Again we constantly remind our colleagues in the community that you don't have to re-invent the mental health wheel to treat veterans and military families. However you do need to approach this population with a culture-sensitive lens. You need to look for a veteran's resiliency and strengths while respecting the individual's own process in telling his or her story and combat experience. It's a matter of looking beyond your own preconceived notions, of understanding what's not being said as well as what is being said, and most important, of looking beyond the obvious.

Survivors of Sexual Abuse: A Personal Journey

By Peter Marino, MA, Group Worker and Marian Rhein, LCSWR, Clinical Supervisor, Personalized Recovery Oriented Services (PROS) Program MHA-Rockland

As part of the Personalized Recovery Oriented Services program at the Mental Health Association of Rockland County, Inc. that began earlier this year, a group named *Survivors of Sexual Abuse-Women* was launched. This closed group, led by Marian Rhein, LCSWR, was designed to serve the needs of women suffering from post traumatic stress after enduring horrific sexual trauma. Initially, eight women were enrolled in the group. Two left as a result of positive discharges to a lower level of outpatient care. One participant decided to drop out finding it difficult to discuss her history of abuse; leaving five women to complete the 6 month program.

During the first session general guidelines were delivered establishing a safe place which embraced confidentially, respect and trust. Individual goals were explored (i.e. eliminate feeling responsible for the abuse, and learn to identify emotions connected with trauma). Each session was ended with a conversation as to whether or not expected outcomes were met. Positive and negative life experiences were shared pin pointing the effects of the abuse and grief endured. Participant's supported one another by acknowledging the courage it took to participate in challenging group discussions. Using the Victim-Survivor-Thriver continuum from Bonnie Collins and Kathryn Marsh's *Healing for Adult Survivors of Childhood Sexual Abuse* (1998) participants identified whether they saw themselves as a victim, a survivor, or a thriver in order to establish a baseline. Participants conceptualized their recovery as the process of moving from Victim to Survivor to Thriver.

Participants discussed often feeling criticized or foolish in the past when expressing their emotions to others. As illustrated in *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (1993) by Marsha M. Linehan, PhD such difficulty has been conceptualized as the effect of an individual persistently encounter an invalidating environment. For example, Collins and Marsh (1998) assert an environment that is shaped by "shame-based family" embraces the following disabling characteristics:

- Feelings are denied, avoided, discounted, and suppressed.
- Family secrets are protected at all cost.
- Control is maintained by fear and secrecy.
- Perfection is expected with no mistakes allowed.
- Blame is freely placed whenever anything goes wrong.
- Love is conditional
- A "no talk" rule prohibits the expression of feelings, needs, or wants
- Trusting no one assures one will never be disappointed.

To help unpack this reality, a selection written by Betsy Rose, "House Full of Secrets" was read silently, then aloud as a group. Each section was analyzed and discussed. Participants connected with the symbolism shown the phrase "and you're caught in the crossfire like a kite in the storm" allowing participants to open up and reflect on the impact of shame on one's sense of self. Participants made a list of things they have difficulty saying No to and what they thought influenced failure to deny or reject when appropriate. Other discussions focused on how individuals think others see them and what individuals would like people to know about them. Difficulty in accepting compliments from others was also shared as well as why individuals tend to hold onto the negative. The participants analyzed another passage by Betsy Rose entitled "Circle of Light" and then wrote a journal entry about how their abuse impacted their lives. Doing so helped individuals to increase participant's sense of control over their lives. Factors in one's life affecting the healing process were discussed including identification of support systems, eliminating self-blame, as well as facing fears were explored. As a result participants grow to understand that there is more than anger, sadness and terror in their emotion spectrum. They find there is also HOPE. Participant grew to accept their anger learning that it can be expressed in a variety of ways or could be perceived as energizing an individual into healthier behaviors or actions.

Continuing through the therapeutic process of understanding and regulating emotion, participants wrote journal entries about their experiences. Prompts included: writing about earliest memories, memories they would want to forget, and organizing timeline of significant life events. In group dialogue, intimacy, trust, and betrayal were defined by relating to experiences in each participants life. Participants increasingly identified people in their lives whom they trusted. Steadily they began sharing how being sexually abused impacted their ability to trust others. Participants wrote additional journal entries about reasons why they may have felt betrayed and what happened to promote these feelings. In the following sessions, participants identified a safe person in their lives and a safe place to spend their time. The impact of how experiencing recurring nightmares and low self-esteem on how individuals perceive trauma was also explored.

Participants celebrated working together while in the course of taking on their own personal journeys. The prevailing theme at the end of six months was added insight, validation and acknowledgement of the possibility that life does not always have to feel as has felt. Participants processed the endpoint of the group for closure, leaving with a sense of growth and a deeper knowledge of themselves. By taking part in the Survivors for Sexual Abuse-Women participants discovered how it the value of trusting themselves equipping them with feelings of empowerment and control that had been stripped due to inerasable events of the past.

Review from page 6

and the need for emotional support. They seem to develop a shift in how they view themselves and the world. Being treated as an object upon whom aggressive and sexual urges have been meted out, the resulting self-view can be one of being less human; more "thing-like." A process of de-humanization has taken place and can be long lasting. In other words, there may be a deep alteration of her self-view, an animalization. She may now also feel sullied, diminished, and undesirable. Her primary emotional state may become one of fearfulness, depression, and weariness of the environment. There can be a pervasive sense that the world is a dangerous place where one's safety and security are far less assured than they were before the rape. The woman has changed in deep and profound ways. She now has a critical and negative view of herself, the motivations of others, and may see the world as a frightening place where vulnerability and threat are the all-encompassing theme. She feels diminished by the environment she once trusted. Rape counseling and both anti-anxiety and anti-depressant medications are now an important part of her life.

Case #3: The final case involves a 39-year-old Rapid Transit worker who witnessed a man being run down and dismembered by a subway train. Unlike the cases above, this worker witnessed the tragic event but was not personally endangered. The *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM-IV-TR;* American Psychiatric Association [APA], 2000) criterion for defining a traumatic stressor indicates that it has to be extremely frightening and that it can either be experienced directly or witnessed.

While this Rapid Transit worker was on duty, a woman frantically ran up to her screaming that there was a man who attempted to cross the tracks and was now being electrocuted. The Transit worker ran to the scene and saw a man glued to the tracks and in spasms. She frantically phoned the train controller to stop all trains because this man could not get off the tracks. She was told that Rapid Transit protocol required that she give a full description of the man including information as to what he was wearing, ethnicity, etc. before any action could be taken. The Transit worker yelled that there was no time for this but did run back to take a closer look and get the needed information. To her utter disbelief a train was rapidly descending upon the entrapped man. In the horrifying final seconds she saw the train hit the man and his separated head flying through the air, his body crushed and torn to shreds.

Now, two and one half years after this tragic event, the Transit worker continues to be plagued by sleeplessness, nightmares, extreme fear, and an all-consuming rage. She feels intense hate toward a system that is so laden with rules, regulations and protocols, that it caused a man's horrific death. She is also angry with herself for not being more effective in convincing the train controller to take immediate action. She feels a pervasive sense of guilt and self-accusation. She in no way resembles the person she was before this event. She is a tormented individual who requires regular psychotherapy and is taking heavily sedating anti-psychotic medication. Her life is radically altered and she is now out of work and on disability. Her world is not the one she once inhabited. Despite having made some progress in therapy, she is a tormented, self-negating, embittered person.

Differential Diagnosis

One of the characteristics that distinguish PTSD from common stress reactions is that it can be long lasting. In fact there are individuals who endured the attack on Pearl Harbor in 1941 who continue to suffer from PTSD after more than

see Review on page 16

Using Virtual Reality for Treatment and Prevention of Post Traumatic Stress and Other Anxiety Disorders

By Joseph M. Brennan, Jr.
Chief Engineer, Institute of Creative Technologies Contract, U.S. Army Research Laboratory, Human Research and Engineering Division, Simulation and Training Technology Center

Significant opportunities for the health and medical communities are becoming available through technological advancements in the Virtual Reality (VR) arena. The Institute for Creative Technologies (ICT), a University Affiliated Research Center, is one example of a research center enabling the Department of Defense (DoD) to capitalize on such advancements. The ICT, which is affiliated with University of Southern California, is managed by the U.S. Army Research Laboratory, Human Research and Engineering Division, Simulation and Training Technology Center. The innovations developed by this research center represent the start of a rapidly growing field. Two of the efforts pioneering this growth are *Bravemind* and *Stress Resilience in Virtual Environments (STRIVE).*

Bravemind

Bravemind is a fully immersive, interactive VR-based application being used to assess and treat military Service Members

Joseph M. Brennan, Jr.

(SMs) who are diagnosed with anxiety disorders such as Post Traumatic Stress Disorder (PTSD). VR provides a promising alternative to traditional *imaginal* exposure therapy in which patients with anxiety disorders are led by clinicians to imagine their traumatic experiences in an incremental, stepwise fashion. *Bravemind* consists of a series of VR environments designed to resemble typical SM trauma settings for use in VR exposure therapy.

One of the advantages of using VR for the treatment of anxiety disorders such as PTSD is that patients can be teleported into virtual environments representative of the traumatic experiences they are seeking to overcome. The intensity of these virtual environments can be configured and adjusted by clinicians using visual, audio, olfactory, and vibrotactile stimuli and triggers so that patients can be immersed in an incremental, stepwise fashion. By exposing patients to their traumatic experiences in a gradual fashion clinicians can assist these patients in progressing towards overcoming their anxiety disorders. In comparison, imaginal exposure therapy relies on patients being able to effectively imagine their traumatic experiences. However, many patients are unwilling or unable to visualize these traumatic experiences. In fact, avoidance of reminders of the trauma is one of the cardinal symptoms of PTSD as indicated by the Diagnostic and Statistical Manual of Mental Disorders, 4th (DSM-IV). Bravemind addresses this potential limitation by offering a means by which to overcome such natural avoidance tendencies.

Multiple open and comparison clinical trials have been performed to test the efficacy of *Bravemind*. In one study, *Bravemind* (referred to as *Virtual Iraq* in its early prototypical stages), produced a statistical and clinically meaningful reduction in PTSD symptoms with SMs who did not benefit from prior traditional forms of treatment. Another study indicated that *Bravemind* was more effective than a cognitive behavioral group treatment in a non-randomized "standard of care" comparison. Other randomized controlled trials associated with *Bravemind* include comparing VR Exposure Therapy (VRET) with imaginal exposure therapy and investigating the additive value of supplementing VRET and imaginal exposure therapy with a cognitive enhancer called D-Cycloserine (DCS). DCS is a broad-spectrum antibiotic that has been used in multiple clinical trials as a cognitive enhancer. DCS has an essential role in learning and memory and has been shown to enhance learning to include the extinction of conditioned fear responses such as those experienced for various anxiety disorders. In one case, it was demonstrated that DCS combined with VRET for fear of heights significantly reduced the number of sessions needed for successful treatment from six to only two sessions. In another case it was found that DCS combined with imaginal exposure was an effective treatment for social anxiety. In one of the PTSD treatment studies conducted at the Walter Reed Army Medical Center some participants have

see Virtual Reality on page 28

Addressing Gun Violence to Combat PTSD in Children

By Fern A. Zagor, LCSW, ACSW
President and CEO
Staten Island Mental Health Society

Children exposed to violence, especially gun violence, are at great risk of developing symptoms associated with Post-Traumatic Stress Disorder (PTSD). In fact, nearly 100% of children who have witnessed the violent death of someone they know, especially a family member, develop these debilitating symptoms. Exposure to violence can cause intrusive thoughts about the traumatic event and sleep disturbances. These symptoms can dramatically affect a child's ability to successfully function at home, school, and with peers. It is not surprising that children and youth exposed to gun violence commonly experience difficulty concentrating in the classroom, declines in academic performance, and lower educational and career aspirations.

If left untreated, PTSD can also lead to alcohol and drug abuse, gang involvement, or inability to sustain healthy relationships or jobs.

School-aged children (ages 5-12) may not have flashbacks or problems remembering parts of the trauma, the way adults with PTSD often do. Children, though, might put the events of the trauma in the wrong order. They might also think there were signs that the trauma was going to happen. As a result, they think that they will see these signs again before another trauma happens. They often bear a sense of responsibility resulting in a sense of guilt for the violence. They may believe that if they pay attention, they can avoid future traumas.

Children of this age might also show signs of PTSD in their play. They might keep repeating a part of the trauma. For example, a child might always want to play shooting games after he sees a school shooting, but these games do not make their worry and distress go away. Children may also fit parts of the trauma into their daily lives. For example, a child might carry a gun to school after seeing a school shooting.

Teens (ages 12-18) are not children, yet not adults. Some PTSD symptoms in

Fern A. Zagor, LCSW, ACSW

teens begin to look like those of adults, but there are differences. For example, teens are more likely than younger children or adults to show impulsive and aggressive behaviors. As a result, they have less ability to manage the fear, stress and anxiety associated with violence. They may try to numb these feelings with alcohol or drugs. Or, they may try to control their circumstances by being the perpetrators - rather than the victims - of violence, through gang activities and the like. Some youngsters may become severely depressed or suicidal.

We know that Staten Island youth are in trouble, and much of that trouble may be due to violence and PTSD. Alarming is the prevalence of alcohol abuse and substance use/abuse among adolescents and young adults. According to the New York City Department of Health and Mental Hygiene and the New York State Department of Health, rates of smoking, binge drinking, alcohol consumption and marijuana use are higher among Staten Island youth than among youth throughout the city and state.

Sadly, there are limited services to address the needs of these disconnected and at-risk youth. On Staten Island, of the 15 outpatient treatment and rehabilitation services licensed by the NYS Office of Alcoholism and Substance Abuse Services, only the Staten Island Mental Health Society (SIMHS) offers services exclusively for youth.

To help close the gap in services for youth suffering from violence-related PTSD, the SIMHS has received a grant of $83,000 from Staten Island Council Member Debi Rose to provide the mental health component of a comprehensive approach to combating the epidemic of gun violence on our borough's North Shore. The SIMHS will partner with other Island stake-holders as part of a citywide coalition that will shift the discourse toward the view of violence as a disease and place the emphasis on finding solutions to end this epidemic. Modeled after the evidence-based "Cease Fire" program that has been implemented successfully across the country, this initiative will work towards responding and reducing gun violence in our community. We plan to provide a full range of evidence-based mental health and related services to children and their families impacted by the epidemic of gun violence.

Targeting youth ages 11 through 21, our program is to be located in the St. George area of Staten Island - the hub of the North Shore community - near the Family and Criminal Courts as well as the Department of Probation and the Center for Court Innovations' Staten Island Youth Justice Center. Funding will be used to support a Spanish-speaking clinical social worker, a part-time psychiatrist, and a part-time coordinator - who is both a clinician and a seasoned administrator - to oversee the implementation of the project. SIMHS clinicians will also undergo training to provide culturally sensitive and appropriate services to children and families affected by gun violence.

One of the treatment approaches that has proven successful in alleviating PTSD is Trauma- Focused Cognitive Behavioral Therapy (CBT), in which the child is encouraged to talk about his or her memory of the trauma and includes techniques to help lower worry and stress. The child may learn how to assert him or herself. The therapy may involve learning to change thoughts or beliefs about the trauma that are not correct or true. For example, after a trauma, a child may start thinking, "the world is totally unsafe."

Some may question whether children should be asked to think about and remember events that scared them, but research has shown it to be safe and effective for children with PTSD. The child can be taught at his or her own pace to relax while thinking about the trauma. That way, the child learns not to be afraid of the memories. CBT may also use training for parents and caregivers, because it is important for adults to understand the effects of PTSD and to learn coping skills that will help them help their children.

Another treatment approach, Psychological First Aid (PFA), has been used with school-aged children and teens that have been through violence where they live. PFA can be used in schools and traditional settings. It involves providing comfort and support, and letting children know their reactions are normal. PFA teaches calming and problem-solving skills and also helps caregivers deal with changes in the child's feelings and behavior. Children with more severe symptoms may be referred for added treatment.

Play therapy can be used to treat young children with PTSD who are not able to deal with the trauma more directly. The therapist uses games, drawings, and other methods to help children process their traumatic memories.

Another promising approach is therapeutic group intervention. Trauma-focused group interventions have successfully treated violence-exposed and victimized children and adolescents. In these settings, youth learn that they are not alone in their feelings and reactions; they are able to draw strength from those with whom they can identify, and, under the skillful guidance of a therapist, begin to find healthy ways to manage their stress, anxiety, and fears.

The SIMHS is committed to working with our local community and with New York City to prevent gun violence in our neighborhoods, and to offer therapeutic healing to those children and families who have been emotionally/psychologically impacted by gun violence and PTSD.

Review from page 14

70 years. Another unique feature of PTSD is the pervasiveness of its impact on psychological functioning. In the cognitive sphere, PTSD can cause memory problems and difficulty in concentration. In the emotional realm it can be the cause of anxiety, depression, guilt, and sadness. In the behavioral realm it is often linked to a tendency to be easily startled, racing heartbeat, edginess, aggressiveness, and a tendency to overreact to common stressors. And finally, as noted above, there is often a phenomenological shift such that traumatized individuals have a far more negative view of themselves and the world than they did previously.

The revised fourth edition of the DSM delineates six criteria for a diagnosis of PTSD: (A) The person experienced, witnessed or was confronted with events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. Typically this includes experiences such as war trauma, rape, and assault but could also include witnessing a horrific event occurring to someone else. One of the more common sources of PTSD in everyday life is a frightening and perhaps injury producing car accident. (B) The traumatic event is persistently re-experienced. This can take the form of intrusive images, thoughts, dreams, or suddenly experiencing the same emotional and physiological reactivity that occurred in response to the trauma. (C) Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness. The latter refers to withdrawal and emotional dampening down. (D) Persistent symptoms

see Review on page 22

— The NYSPA Report —
Medicaid's Fragmented Formularies

By Barry B. Perlman, MD
and Jessica Daniels, MD

To control the spiraling cost of medications to the NYS Medicaid program, the NYS budget adopted during 2011 radically altered the way the program purchased and paid for that formulary. The previously unified Medicaid formulary was fragmented such that each Medicaid HMO was required to define and manage its own formulary for its members. For those who were to remain in the Medicaid FFS system until they were moved into managed care, a more restrictive formulary was defined. Previously, given the state's concern about the vulnerability of special populations, such as persons with serious and persistent mental illness, certain classes of medications, such as atypical antipsychotics, were not subject to restriction. This was no longer to be the case.

As a result, physicians and patients were faced with a virtual "Tower of Babel" of disparate formularies to negotiate and with new formulary programs fraught with barriers.

In the past obtaining approvals from the Medicaid formulary for non preferred medications was a relatively straightforward process which could be concluded in a timely manner by dealing directly with the Medicaid formulary. After the implementation of the law, such was no longer the case. Furthermore, the long standing "prescriber prevails" clause of the law, which assured patient protection, was not included in the new law governing Medicaid managed pharmacy, thus vesting the ultimate decision about which medications, including psychotropics, to the managed care companies. To the surprise of many psychiatrists, because appeals for non preferred medications were now within the province of the HMOs, the more complex and time consuming NYS laws and regulations applicable to managed care utilization review and external appeal now came in to force. These permit the process to be stretched into one which may take days or even weeks despite time being of the essence in these situations. While some companies tried to expedite medication related appeals, there was no requirement that they do so.

Psychiatrists found the new landscape frustrating and to have a negative impact on patient care. For example, many psychiatrists who had participated in the NYS OMH PSYCKES Quality project which encouraged clinicians to move patients from atypical antipsychotics adjudged to put them at increased risk for certain health issues to lower risk medications found that the preferred medications were often not on the HMO or state formulary. Another example was the failure to coordinate "plan" formularies with those of the hospitals. The consequence was a frequent need to change psychoactive medications at the time of discharge with the potential for destabilizing patients' clinical conditions at the time that the state was emphasizing the importance of coordinated discharge planning. Administra-

Barry B. Perlman, MD

tively, psychiatrists encountered many barriers to gaining approval for a non formulary medication from the patient's HMO. Calls were required or forms faxed and layers of bureaucrats with varying knowledge or lack thereof had to be negotiated with, often without timely resolution of the matter. How user friendly HMOs processes were was highly variable. There seemed to be no clear expectations of them in terms of their execution except that that they abide by above mentioned laws and regulations which did not easily lend themselves to the urgency of medication appeals. Time spent in making the initial request often took 15 minutes or more and the process often did not end there. Remember also that given the pressure in clinics for productivity, such an appeal could use up much of the limited time allotted for visits, diminishing the patients' experience of their time with their doctor. Indeed, patients might often leave without the certainty that they would receive the preferred psychotropic medications on a timely basis.

Psychiatrists reported that appeals were consuming as much as 25 % of their time, resulting in their seeing fewer patients than in the past. A psychiatrist carrying a caseload of 200 patients working in a busy medical clinic specializing in the care of persons with HIV described what she has encountered. The process often requires that she make repeated phone calls, wasting time trying to figure out which number to call, spending long periods of time on "hold," speaking to untrained representatives who act as intermediaries, and dealing with a vexing reliance on faxing. Then, given the shift in the balance of decisional authority and the infrequent ability to discuss the clinical situation with a knowledgeable clinician, not being certain that the patient will receive the most appropriate medication. This psychiatrist recalls trying to gain access to needed medications to avert an emergency department visit for a patient with mania who was experiencing a decompensation. She found herself making repeated calls to the Medicaid HMO late into the evening but only being able to speak with representatives lacking decisional authority as well as to a pharmacist who said 24 hours would be required for a decision. The new system failed the patient despite the psychiatrist's best efforts. She observed, "that since the change in the law it has become much more laborious to keep patients stable on their medications – if a patient in tenuous condition cannot pick up their medication immediately, the odds on them going back to the pharmacy to pick it up later drop dramatically." While what we mention are anecdotes, they are common stories shared among psychiatrists working to navigate the new system. As we can see, it all adds up.

NYSPA, aware of the too rapid rise in the costs of psychotropic medications to the NYS Medicaid Formulary, issued a "White Paper" in 2003. (See the NYSPA Report in the Summer, 2005 issue of Mental Health News.) Against the commonly held view of mental health advocates, it called for the inclusion of psychoactive medications in restricted formularies but balanced that recommendation by calling for a series of patient protections, including the preservation of the "doctor prevails" clause, to assure that their patients would receive the indicated medications and that their scarce time would not be devoured by cumbersome review processes. The scheme put into place in 2011 achieved neither those goals.

Psychiatrists voiced their concern about the impact of the newly implemented scheme on their most severely ill patients and advocated for redress. The legislature restored the "doctor prevails" requirement for the use of atypical antipsychotic medications beginning as of 1/1/13. Despite the fact that Medicaid HMOs will continue to be able to require psychiatrists to deal with the too often excessive hassles of their appeals processes, this change is viewed as an important first step towards restoring a balance in favor of quality patient care. Also, the NYS DOH, recognizing the extent of the problem, convened an ad hoc workforce force to review and modify the process. We are pleased to be participating in the work of that workgroup. That group is currently reviewing the present state of program and is expected to make recommendations and/or take steps to mitigate the worst aspects of the current approach. Psychiatrists and advocates for those with mental illness will need to monitor its work product closely. NYSPA plans to advocate for additional legislative remedies during the coming legislative session. It will seek to have all generic psychotropic medications included in the formularies of the Medicaid HMOs and for them to be available for physicians, including psychiatrists, to prescribe without prior approval or, at least, under the condition of "prescriber prevails." Given the significant increase in the number of important psychotropics, including many of the atypical antipsychotics, which are now available as generics, as compared with what was available in 2003, adopting such a change now would greatly reduce the valuable psychiatric time expended in appeals and better serve patients and their psychiatrists and, perhaps, even the HMOs. Finally, we seek an appeals process which will be no more cumbersome than the one which was in place prior to the changes in the law.

Barry B. Perlman, MD, is Director of the Department of Psychiatry at Saint Joseph's Medical Center in Yonkers, New York, and is Past President and Legislative Chair of the New York State Psychiatric Association. Jessica Daniels, MD, is Assistant Professor of Psychiatry at the New York Presbyterian Hospital – Weill Cornell Medical Center in New York City.

Post Traumatic Stress Disorder: The Person Within

By Lois Tannenbaum, PsyD, CBIS, LEND Fellow, Brain Injury Program Coordinator, Putnam ARC

Post Traumatic Stress Disorder is not an inherent weakness in facing difficulty, nor is it a flaw in an individual's personality, belief system, or values. The development and intensity of PTSD symptoms is concordant with the intensity and duration of the stressful event encountered.

The experience of death and/or trauma is always difficult to assimilate into our lives. A former reality based on a belief system that was rooted in a trust that life is good and will remain so, has been threatened and violated in some manner and the magnitude of its impact will forever change lives. The isolated or collateral experience/s result in grieving as we move towards acceptance to a greater or lesser degree; at a divergent pace; dependent upon such variables as age, illness, relationship, and the circumstances of the trauma.

There are residual effects that affect those involved in the aftermath of that trauma which evidence as Post Traumatic Stress Disorder (PTSD). PTSD is a psychological wound sustained when a person is exposed to an overwhelmingly stressful event. This may occur as a primary (direct) exposure that an individual witnesses or experiences in some manner. However, it may also be a secondary (indirect) exposure to a caregiver, family member, friend, or significant other as a result of his/her relationship to the directly affected person. For me, just as has been the case for many others, the personal experience of PTSD has been both secondary and primary.

In 1995 I fell in love with a man who initially appeared to be friendly, outgoing, and eager to love and be loved. However, after we began to share our lives together, it wasn't long before he suffered dark symptoms related to PTSD. The love of my life was a veteran of the Viet Nam war and had served two tours of duty there surrounded by death and cumulative trauma. He was cynical, non-trusting, socially isolated, and had repetitive bouts of depression. These bouts would result in weeks of his being non-communicative and spending excessive amounts of time in complete darkness. I experienced a great deal of frustration as I expended limitless energy in firmly believing that my extroverted, optimistic, and accepting nature of being a "people person" would spill over and bring him into the light. Instead, I spent a great deal of time feeling sucked into the darkness. I can't begin to calculate how many days I would return home from work to find my home in complete darkness which left me sitting almost paralyzed on the driveway not wanting to go in. The hours I spent alone always left me devastated and constantly searching within for answers, for strength, for solace.

For five years we lived together and weathered the highs and lows that are part and parcel to PTSD. We took small steps forward and made slow but steady headway towards compromises of light that could penetrate the darkness. We attended counseling, planning and working diligently for our future. We made a major decision to take a trip that would be a first experience for both of us; a short 4 day cruise to the Bahamas following a couple of days touring Florida. We shared new experiences and days filled with laughter and plans for a brighter future. On our way to Fort Lauderdale where we would board the cruise ship, our vehicle was struck by a drunk driver. The man I loved died in my arms from an open head trauma, and in that fleeting moment I entered an unfamiliar darkness and crossed the line from PTSD caregiver to PTSD victim. I could never have imagined that 8 years later my son, my only child would sustain a work related severe brain injury that would pummel me back and forth across that line.

What saved my sanity? How did I endure the emotional trauma to find my way out of the devastation? After the initial trauma, I unsuccessfully tried a few therapists. Finally, I was referred to a therapist who had lost her only child to an automobile accident, and also had learned to be the caregiver of a Vietnam era veteran husband who lived with PTSD. The support and guidance she provided, and the strategies she shared, enabled me not only to rejoin the land of the living emotionally, but also to pursue my doctoral degree in a field in which I could help others. Every lesson I learned was painstakingly retrieved from my toolbox when once again I faced the terrible trauma of son's accident. The two most important lessons learned: recognize the symptoms; bravely seek help and support!

Do not despair, seek help.

Normalcy does not resume, we reconstruct it .

Such is the wisdom of Tragedy.

PTSD symptoms are experienced and expressed in a manner unique to each individual and include: event re-experiencing; anxiety; avoidance; depression; isolation; social disconnect; arousal; hyper-arousal; occupational dysfunction; and substance abuse.

There are multi-variant factors that contribute to the following individual outcomes of healing. Those with a

see Person on page 32

Healing PTSD Through Relationship and Touch

By Richard Beauvais, PhD
Wellspring Co-Founder

When six year old Mandi* came to us, she had suffered significant trauma in her early years from a drug -addicted mother, a father in prison, and several disrupted foster placements. She reacted to any limit setting with uncontrollable tantrums, terrorizing and discouraging her latest well-meaning but uninformed foster family, whose only recourse as instructed was to send her to a time-out room alone. Mandi repeatedly trashed the room in her rages. With no answer for her outbursts, the family could no longer bear them. As a last resort, she was sent to Wellspring, a multi-service mental health agency in Bethlehem, Connecticut, for residential treatment.

Post Traumatic Stress Disorder has two faces: The first results from specific events, like rape and the impact of other forms of violence and terror; the second is *cumulative*, resulting from repeated abuse, abandonment and neglect during the first three years of life. Mandi suffered from *cumulative* trauma, which also contributed to her problems with attachment.

The neurobiology of these two forms of trauma is similar in many respects. With *cumulative* trauma, memory of early traumatic mother-child interactions remains pre-verbal or non-verbal, encoded in the brain body. These traumatic residues take the form of reactive trauma templates, which trigger seemingly unrelated and disproportionate responses to circumstances and events. Because these physiological, neurological and emotional processes are sensory based and reactive to stress, they tend to operate outside of cognitive, verbal processing. Because these memories have no words, and words cannot reach them, treatment and parenting must incorporate other modes of processing than cognitive verbal approaches or behavior modification alone. This has major implications for the treatment of traumatized, attachment resistant children like Mandi, but also for traumatized adolescents and adults.

If treatment is to have any hope of success, it must be relational. In his seminal work on the neurobiology of affect development, Allen Schore showed how the developing brain is shaped by early relational experience for better and for worse. The question is whether and how it can be re-shaped by corrective relational experience in later life. Martin Teicher at Harvard claims that the brain is already hard-wired by the age of three, so whatever has happened cannot be undone. Others such as Siegel, Cozolino and Farber claim that brain pathways can be altered through the continued plasticity of the orbito-frontal cortex. What this requires, however, are qualitatively different relationships that provide safety, closeness, caring and support. But both positions are true, for if change comes only through the quality and consistency of relational care, that care regrettably may not be available to most of these children.

Mandi was just as reactive initially at Wellspring. However, with our understanding of the traumatic underpinnings of her reactivity and our experience with children, staff learned quickly that by scooping Mandi up into their arms and holding her close, she calmed down quickly, allowing herself to be comforted and cared for. This gradually established a bond with the child based on care and trust. At our request, this intervention had been authorized in advance by state service providers (legal guardians) and by Mandi's foster parents, because we were confident it would work. The question is why did it work?

Bessel van der Kolk, a recognized authority on trauma, made this salient point about effective treatment. "Because young children and threatened adults cannot inhibit emotional states that have their origin in physical sensations," approaches to treatment and parenting need to be modified to incorporate "bottom up" rather than "top down" modes of processing. Because traumatic memory is implicit, or sensory based, rather than verbal, "bottom up" modes of intervention and processing for PTSD are body-based and sensory focused. They are specifically designed to address the critical role of stress in generating trauma-based emotional reactivity and behavior. Treatment not only works through the medium of corrective relationship for the long term, it must also manage stress in the short term, so that positive relational experiences from therapy and parenting can have a healing effect. These two dimensions of intervention and care must be woven together.

The cornerstone of "bottom up" processing, particularly with traumatized, attachment resistant children, is safe, healing touch. Touch is a powerful medium for both healing and for harm, because it directly contacts the body, the senses and the emotions. As a medium for receptivity and mutual exchange between the physical and psychic fields shared between people, touch is profoundly relational. The ability of touch to provide comfort and establish heart-to-heart connection makes it an ideal mode for "bottom up" processing.

What Mandi responded to so positively was the simple act of being held, soothed and comforted, rather than being sent off alone to her room. Scooping, as we called it, brought relief from the traumatic impact of how she experienced limit setting as a basic rejection. It relieved stress and

see Touch on page 32

Review from page 16

of increased arousal, e.g. difficulty falling or staying asleep, irritability and outbursts, difficulty concentrating, and exaggerated startle response. (E) Duration of disturbance of more than a month. As noted above, PTSD can last for many decades. (F) The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning. This criterion rules out more transient and less debilitating responses. Two important differences between the DSM-III and IV were that the latter dropped the requirement that the trauma experience be beyond the range of normal experiences and the DSM-IV also placed an emphasis on the fact that the trauma experience must cause extreme fear.

While there is little doubt that those who have been traumatized experience negative emotional, cognitive, and behavioral consequences, this does not necessarily validate the specific criteria as set forth in the DSM IV. A good argument can be made that there is a commonality in the responses to extreme stress whether that stress is due to war, rape, or car accident and that these commonalities are reflected in the DSM criteria. It can be further argued that war related phenomena such as soldiers heart, shell shock, war neurosis, railway spine (the hypothesized neurological condition that eventuates from railroad accidents), rape trauma syndrome, etc. are all terms that describe PTSD prior to the existence of this term. However, one can reasonably question whether there is empirical grounding of all of the phenomena that are said to represent PTSD in the DSM.

For example during the 1970's anti-Vietnam War psychiatrists Robert Lifton and Chaim Shatan argued that the stress of war produced psychological problems of a delayed onset (McNally, 2011). They teamed up with leaders of various Vietnam veterans' organizations to lobby the American Psychiatric Association to include a diagnosis of "post Vietnam syndrome" so that veterans could receive Veterans Administration benefits in order to help them deal with atrocities that eventuated from what was viewed as an immoral war. A later strategy used by Lifton and Shatan, which ultimately proved successful, focused upon the position that all extreme trauma's resulted in a common set of symptoms regardless of whether the trauma was due to rape, war, car accident, criminal assault, etc. Thus, there was nothing unique about the Vietnam War. It was simply one among many major stressors that produced dysfunctional symptoms.

This more general strategy worked and post Vietnam syndrome was dropped and replaced with posttraumatic stress disorder in the 1980 version of the DSM, i.e. DSM III. This change exemplifies that the diagnostic criteria for PTSD may be influenced as much by social construction and clinical impression as it is by research based empirical findings. In fact, one of the distinguishing characteristics of PTSD is flashbacks, or the sudden, intense re-experiencing trauma stimuli and the resultant extreme anxiety. However, in a careful analysis of data from World War I and World War II, the existence of flashbacks was virtually unheard of (McNally 2011).

Secondary Traumatization: PTSD is not only debilitating to the individual, but also its negative effects often spread to others through a process called secondary traumatization. Secondary trauma refers to the process by which trauma reactions are passed onto those who have close and extended contact with the traumatized individual. This suggests that PTSD and trauma reactions in general have a contagious nature to them. While there is far less research on secondary trauma in comparison to PTSD, available studies show that while secondary trauma reactions generally result in a negative affective state, the intensity of these negative reactions is often less than that of primary trauma (Suozzi & Motta, 2004).

So, for example, when a person within the family suffers from PTSD there is an increased likelihood that the spouse and children will also develop symptoms similar to those of the trauma victim but these reactions will be less severe. The trauma victim's negativism, anxiety, social alienation and suspiciousness have a palpable impact on family members. Those experiencing secondary trauma have not directly encountered a traumatic event but have acquired trauma symptoms vicariously, often through close contact with trauma victims. The terms "vicarious traumatization" or "compassion fatigue" are often used in these contexts and in situations where therapists acquire negative affective states as a result of dealing with trauma victims (Figley, 1995; McCann & Pearlman, 1990).

Rosenheck and Nathan (1989), in one of the first systematically documented investigations of secondary trauma, presented a case of a 10-year-old son of a Vietnam War veteran. This child was shown to have an obsessive preoccupation with the father's war experiences. He suffered guilt, anxiety, and outbursts of aggressiveness. In many ways, his symptoms mirrored those of his father. In another study, Parsons, Kehle, and Owen (1990) compared the children of Vietnam combat veterans with PTSD to Vietnam era veterans without PTSD. Overall, children of veterans with PTSD appeared to have greater difficulties in the areas of social and emotional functioning. They did not initiate and maintain relationships effectively. They were also found to be lacking in self-control and to display more aggressive, hyperactive, and delinquent behaviors. Many of these behaviors are characteristic of those with PTSD, especially the social isolation, emotional withdrawal, the tendency to become easily agitated and aggressive.

Secondary Trauma Research

Much of the early research work on secondary trauma began with studies of how therapists are negatively affected by their work. This form of secondary trauma is frequently labeled "vicarious traumatization." It refers to a "transformation in the therapist's…..inner experience resulting from empathic engagement with clients trauma material. "These effects are cumulative and permanent, and evident in both a therapist's professional and personal life." (Pearlman & Saakvitne, 1989 p.151). The therapist, who works extensively with rape victims, may begin to display the same wariness, depression, diminished sense of self and lack of optimism as the patients in treatment.

see Review on page 26

Who We Are and How We Arrived at Today: Thirty Years of Treating People Who are Trauma Survivors

By Liane Nelson, PhD, Director Treatment Center for Trauma and Abuse, Westchester Jewish Community Services (WJCS)

The WJCS Treatment Center for Trauma and Abuse (TCTA) has been in the forefront in providing mental health services to survivors of childhood sexual abuse, and other forms of trauma, in Westchester County for the past 30 years. Many of the individuals seen through this program have a diagnosis of Post Traumatic Stress Disorder (PTSD) complicated by other factors. It is important to recognize the evolution in understanding, diagnosing and responding to individuals with histories of trauma, particularly children who have been traumatized in their own home during their formative years. In many ways, the growth and success of the WJCS Treatment Center for Trauma and Abuse parallels the discovery and understanding of childhood sexual abuse in our society, and more specifically in the mental health arena.

In the field of mental health, child sexual abuse was first discussed by Sigmund Freud in the 1880s and 1890s. In the course of conducting psychoanalysis he heard from his adult patients about situations in which there were clear indications of sexual abuse during childhood. In fact, they told him that they had sex with adults when they were children. Initially he believed his patients and connected these experiences with adult psychopathology, in particular, anxiety and neuroses. When he made this information public through his writings, he experienced a professional backlash from colleagues who did not believe that children were sexually abused.

Therefore, he developed a secondary theory that the reported childhood sexual experiences reflected unconscious wishes and desires, and did not necessarily have a basis in fact. This "blaming of the victim" caused a setback in understanding and responding to sexually abused children by the mental health profession (and society as a whole) that lasted a very long time.

Individual contributors sporadically acknowledged that child sexual abuse was a problem, such as in the Kinsey Report of 1948 in which nearly one quarter of the women respondents stated that they had sex with adult men when they were children, or had been approached by an adult male looking for sex. However, this information was largely ignored.

Recognition of the issue of child sexual abuse as a significant problem affecting many children, as well as the recognition of the problem of sexual assault and rape, did not happen until the 1960s and 1970s with the Feminist Movement. By 1982, the problem of childhood sexual abuse had permeated the national psyche, and daycare scandals in California and New York served to establish that the problem was nearby and prevalent.

Understanding that existing clinical resources were inadequate to address the traumatic impact of sexual abuse and violence on child survivors and their families, the Westchester Count Department of Community Mental Health issued an RFP to fund the establishment of a child sexual abuse treatment program.

Liane Nelson, PhD

Intersted in taking on a new project, WJCS social worker Alan Trager was given the job of developing the newly funded "Victims of Incest Program," along with another staff person. They attended specialized trainings to get up to speed as quickly as possible. They handled individual treatment with incest survivors, incest perpetrators, and family members; conducted groups; and managed a 24-hour Incest Hotline.

On January 9, 1984, a New York Times reporter attended a WJCS group for adult incest survivors and published an article, on the same day as the airing of the first made-for-TV movie about incest, "Something About Amelia." The demand for expert commentary propelled Mr. Trager into the pantheon of child sexual abuse experts and put the Victim of Incest Program solidly on the map in Westchester County. Additionally, the movie spurred an unprecedented number of calls to sexual abuse hotlines, further establishing that this problem was real, sizeable and needed a coordinated response from mental health experts.

Now in its 30th year, TCTA staff provide trauma-informed, evidence-based mental health treatment for children and adults affected by sexual abuse, children and adults affected by domestic violence, and participants in a program for Juveniles with Problematic Sexual Behavior (Juveniles Starting Over). With a current staff of 12, our clinicians offer services at all four WJCS mental health clinics across the county. Last year, the program treated 241 children and 240 adults.

The professional and societal understanding of childhood sexual abuse and the WJCS program have evolved with increased knowledge, research, and experience in treating survivors of childhood sexual abuse. TCTA is comprised of a multidisciplinary treatment team including psychiatrists, psychologists and social workers. The program provides specialized supervision and training for five graduate students in social work and psychology. During regular weekly meetings, we get an opportunity to learn from each other, present clinical cases, attend to vicarious trauma issues,and foster a strong, cohesive unit. The team borrows a concept from Dialetic Behavior Therapy in using mindfulness exercises to help do this difficult work most effectively while being attentive to self-care.

The TCTA team addresses vicarious trauma issues in an ongoing way, recognizing that to ignore this occupational hazard of working with trauma survivors has great cost. It can be tempting to put discussion of vicarious trauma on the back burner when issues that appear more urgent emerge, but in order to do this work most respectfully and efficiently vicarious trauma must be addressed.

One of the challenges our clinical team has identified is recognition of the limitations of Post Traumatic Stress Disorder (PTSD) as a diagnosis for many of the adults and children we treat. PTSD is a diagnosis with a history dating to World War I when it was acknowledged that soldiers exposed to war trauma could have "invisible" psychic wounds. It was initially termed "shell shock." The ability to apply a construct that historically refers to the experiences on a battlefield that happen to adults, and may be the only traumatizing experience of that adult's life, to adults with more complex trauma histories of child sexual abuse is not always possible.

TCTA staff rarely, if ever, see people who are affected by only one traumatic event. Complex trauma more fully acknowledges that people are often traumatized by multiple and/or chronic and prolonged traumatic events, with an early-life onset, and often they occur within the child's care-giving system. These traumatic events may include physical, emotional, sexual and educational neglect, and other forms of child maltreatment. Often, this more accurately describes adults seen in our program.

Another area of difficulty in applying a straightforward diagnosis of PTSD is with children. Children are not miniature adults, and it can be misleading to attempt to diagnose a child, especially a young child, separate from the context of his/her relationship with the caregiver. For this reason, we are encouraged by Bessel van der Kolk's Developmental Trauma Disorder, which attends to the profound importance of attachment relationships in mediating traumatic events. We applaud his efforts to have this diagnosis acknowledged

see Survivors on page 24

Training from page 12

"prolonged exposure therapy is highly effective in treating PTSD, and results in substantial treatment gains that are maintained over time." The core of prolonged exposure therapy is the repeated description of the memory in vivid detail in a safe environment; through this, the patient learns that the memory itself is not dangerous, which then enables them to cope with the attendant memory and resultant anxiety."

Many clinicians are nonetheless reluctant to employ exposure-based interventions in their practices because they lack the comfort level and skills that adequate training provides. It is our aim in developing this training, to overcome this obstacle and to increase the number of mental health specialists capable of providing exposure-based intervention for patients with PTSD.

By presenting the theoretical cognitive-behavioral principles of exposure therapy and the evidence-based data supporting its use in the treatment of PTSD and other anxiety disorders, we expect that those taking the training will gain a better understanding of what prolonged exposure therapy is and why it is an effective treatment option for patients with PTSD. Because exposure therapy makes unique psychological demands on the patients, the training also help learners develop a strong therapeutic alliance with their patients and gain the skill, knowledge and self-confidence necessary to effectively present the rationale for the therapy to those they treat, to explain to them what exposure therapy is and how it works, as well as what can be expected from the treatment, both in the short- and the long-term.

The majority of the training is a blend of didactic and interactive/experiential learning, and aims to help clinicians develop a better understanding of how to conduct prolonged exposure therapy in their practice. This part of the training explains: the structure of prolonged exposure therapy, how to start patients on prolonged exposure therapy conduct imaginal exposure, build an in vivo hierarchy, recognize when the client is under or over-engaged, manage anxiety levels so the patient remains within an effective range of engagement, and know when it's appropriate to terminate therapy. We hope that learners will come away from the course feeling confident in their abilities to conduct prolonged exposure therapy and motivated to learn more about it.

The Common Goal

By offering these two CME trainings to an unlimited number of primary care and mental health professionals in New York City the DOHMH hopes to increase the number of trained professionals capable of providing the needed care to those psychologically impacted by disasters and other traumatic events. Integrating mental health services into primary care and increasing the number of trained mental health professionals capable of providing evidence-based exposure therapy will help mitigate the consequences of undetected or inadequately treated trauma related disorders. We encourage primary care practitioners and mental health professionals in New York City interested in receiving additional information about these free trainings to forward your contact information to DOHMH by e-mailing tsmith9@health.nyc.gov.

Survivors from page 23

and find it clinically useful when considering the factors that cause a child to be negatively impacted and/or resilient.

Finally, the TCTA program is flexible and clinically sophisticated in providing different treatments for individuals who have experienced trauma. Historically, individual play therapy had been used in addressing trauma in children. While play therapy techniques may be used with skill and effectiveness, we have moved toward a stronger appreciation of evidence-based practice and modalities that maximize parental participation, as much as possible.

The evidence based practice of Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has been embraced and mastered by our staff and is the most widely used treatment employed by TCTA clinicians who treat children. All staff are trained in TF-CBT and supervised by adept TF-CBT practitioners. While TF-CBT incorporates parallel child and parent sessions, with the parent and child coming together for sessions at the conclusion of treatment, we also use family therapy, where appropriate, in order to attend to the repair of attachment bonds.

Another recent initiative, funded by the Westchester County Youth Bureau, is a trauma-informed group for parents of young children who have been affected by violence. In attempting to address the treatment barriers experienced by multi-stressed people, we provide child care, dinner and Metrocards to participants. We address a variety of topics, with the goals being to increase the social support experienced by the parents in our group, and to provide them with skills and opportunities to discuss issues related to trauma and parenting young children. It is key to understand that often the most profound way of positively affecting a child's life is to help strengthen his or her parents.

Our society, and specifically the mental health field, has come a long way in understanding, diagnosing and responding the traumatic impact of childhood sexual abuse on individuals and families. The WJCS Treatment Center for Trauma and Abuse has been in the forefront in Westchester County in promoting this understanding with quality clinical and training programs. The diagnosis of post traumatic stress disorder has been a part of the evolution in understanding the deleterious impact of abuse on children. However as our knowledge in this field matures, so must our assessment and diagnostic categories. We look forward to being part of a future that not only promotes a deeper understanding of this problem but keeps pace with new diagnostic categories and new models for treatment that promote healing with a focus on resilience and prevention of further trauma.

Dr. Nelson is Director of The Treatment Center for Trauma & Abuse, a program of Westchester Jewish Community Services (WJCS)

Practice Principles for Group Work with Children and Adolescents In the Aftermath of Disasters and Other Traumatic Events

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

Following are four interrelated and overlapping practice for group work with young people impacted by disasters and other traumatic events; to help them to build coping skills and overcome isolation. These principles can be (should be) incorporated into any evidence-based practice that utilizes group counseling.

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.

Principle 2. Create groups for survivors that re-establish connections and rebuild a sense of community. Collective trauma, according to Kai Erikson, 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.

Andrew Malekoff, LCSW, CASAC

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." He 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 heir 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 the most distressing troubles. 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. Included in the illustrations to follow are groups that use activities to elicit loving memories and to manage the stress of intrusive reminders.

These four principles offer readers a framework for group work with children and adolescents in the aftermath of disaster. Good planning, knowledge of the stages of group development and careful attention to transitions in the group are also critical components of a successful group work with this population.

Andrew Malekoff is Executive Director for North Shore Child and Family Guidance Center, Roslyn Heights, New York. E-Mail: amalekoff@northshorechildguidance.org.

Review from page 22

These emotional reactions wear on therapists and the stress associated with therapeutic work may cause them to leave the field. "I (Figley, 1989, pg.6) expressed dismay about seeing so many colleagues and friends abandon clinical work or research with traumatized people because of their inability to deal with the pain of others." "At the same time, in spite of the clear identification of this phenomenon as a form of traumatization in all three versions of the DSM, nearly all of the attention has been directed to people in harm's way, and little to those who care for and worry about them."

As with primary traumatization, those who experience secondary trauma experience an alteration of their world-view and sense of self. Their perspectives move to the negative and they no longer see themselves as having the same degree of control of what happens in their lives. Perlman and Saakvitne (1989) would argue that there is a difference between secondary traumatization and vicarious traumatization. The former term is more symptomatically descriptive and the latter is more a roadmap of the inner life changes that occur primarily in therapists who treat the distressed. However, there is little empirical work to support such as dichotomy.

Vicarious trauma and secondary trauma are different perspectives of the same phenomenon. Vicarious traumatization appears to be focus on a description of the perceptions, views, and cognitions of those who are traumatized and secondary trauma appears to have more of an emphasis on displayed symptoms. Nevertheless, both vicarious trauma and secondary trauma are terms used to describe the transfer of distress from one individual to another, and how that distress manifests itself and in that sense do not differ from each other (Bober & Regehr, 2006; Jenkins & Baird, 2002). The terms are considered to be synonymous for most discussions of the transfer of trauma.

Secondary trauma has been investigated in a number of different contexts. Studies have been conducted on children of children of Vietnam War veterans (Suozzi & Motta 2004); firefighters, and police officers (Dwyer, 2005); partners of those who have been sexually abused (Nelson & Wampler, 2000); wives of combat veterans with PTSD (Waysman, Milkulincer, Solomon, & Weisenberg, 1993); grandchildren of Holocauset survivors through intergenerational transfer of symptoms (Libove, Nevid, Pelcovitz, & Carmony, 2002; Kassai & Motta, 2006; Kellerman, 2001; Perlstein, & Motta, 2012); in family members of those with a serious illness (Boyer et al., 2002;), and in children of parents with serious emotional disturbance (Lombardo & Motta, 2008). Children who live in families with one or more traumatized family members often show increased moodiness, withdrawal, academic decline, and problems in social interactions. Secondary traumatization is a spread of negative effects of trauma to others. Unlike many physically contagious diseases, its treatment is not that well defined.

Although somewhat controversial, it has been argued that secondary trauma can occur as a result of witnessing or viewing trauma even when one does not have direct involvement with those who are imperiled. So for example, some would claim that witnessing traumatic situations on television such as the terrorist attack on the World Trade Center, combined with an inclination to fearfully identify with those in the trauma situation, can also result in secondary trauma reactions (e.g., Marshall & Galea, 2004; Propper, Stickgold, Keeley, & Christman, 2007). This latter area is clearly in need of further research work.

Hypothesized Bases of Secondary Trauma

Despite the relative dearth of research on secondary trauma in comparison to PTSD, available studies strongly suggest that it is real and calls for treatment. It is not entirely clear as to how and why people acquire the trauma reactions of others. Social learning theory would propose that simply observing the behavior of others could alter one's perceptions (Bandura 1967). A conscious or unconscious cognitive processing component would not be required. Simply viewing events would be all that is needed. One of the better examples of the negative impact of simply viewing troubling events is seen in the behavior of primates. Rhesus monkeys observing fearful reactions in other monkeys will acquire fear reactions themselves. What is even more surprising is that this fear acquisition takes place even when the rhesus monkeys watch fearful monkeys in a video presentation only (Mineka & Zinbarg, 2006). This situation might be similar to a child becoming fearful by viewing disturbing events on television. Humans and other animals appear to be programmed to acquire secondary trauma reactions and these reactions may have had survival value in the past.

One might reasonably question why we are so adept at acquiring the reactions of others who have been traumatized. While there is no clear answer to this question, it is possible that the ability to be negatively affected by others who have been traumatized has species survival value. We seem to be genetically programmed to be social beings and thus are affected by the concerns of the members of our society (Cacioppo & Patrick, 2008). It is possible that our ancient ancestors who were less capable of acquiring the fear and trauma responses of others may have been less able to adapt to life threatening situations, may have had reduced survival chances, and consequently less opportunity to reproduce (e.g., Dawkins, 1976). Dawkins might take the position that genes are the masters of our behavior and that those genes underlying the ability to acquire the fear reactions of others would eventually become dominant among our ancestral survivors. We carriers of those genes would become more abundant than those not carrying the dominant genes. It is possible that individuals not carrying the genetic predisposition to acquire secondary trauma reactions would have had lower survival prospects and therefore would be less likely to become our progenitors. It would appear that responsiveness to vicarious fear and threat is what has allowed us to survive as a species.

Assessment of Secondary Trauma

While there are a large number of readily available scales for assessing PTSD and primary traumatization (e.g., Post-Traumatic Stress Disorder Checklist [PCL]; Clinician Administered PTSD Scale [CAPS]) and a description of these could be a book in itself, there are few such scales for secondary trauma. Given the ready availability of valid and reliable PTSD scales, they will not be detailed here. Secondary trauma, by contrast, is comparatively bereft of assessment procedures and the measures that are available have some significant weaknesses. The scales that do exist are either designed for a specific population, usually social workers, lack cutoff scores, or both.

Figley (1995) for example, developed a scale called the Compassion Fatigue Self-Test of Psychotherapists (CFST). This scale is used specifically for mental health workers and lacks cut-off scores that would be indicative of emotional disturbance. Similarly, Bride, Robinson Yegidis, and Figley (2003) developed the17 –item Secondary Traumatic Stress Scale (STSS), which measures intrusion, avoidance, and arousal symptoms associated with the stress of professional relationships between social work practitioners and their traumatized clients. The scale shows strong psychometric characteristics but lacks cutoff scores that are associated with reliable and valid measures of disturbance. The same can be aid for the Traumatic Stress Institute (TSI) Belief Scale (Pearlman & McIan, 1995) which measures disruption of beliefs of safety, trust, esteem, intimacy and control among mental health professionals. The above scales place a particular focus on secondary trauma among mental health professionals but secondary trauma has a much wider scope that includes spouses, children, siblings, etc. of those who have been traumatized.

The Secondary Trauma Scale (STS; Motta, Hafeez, Sciancalepore, & Diaz, 2001) was designed to assess secondary trauma not only in mental health professionals but also in the general population. This 18-item measure has evolved over a series of studies and has been used in therapist, student, and community samples. It has strong internal consistency and test-retest reliability, and good concurrent, content and discriminant validity. Its clinical utility is enhanced by the availability of cut-off scores. For example, scores on the STS at or above 38 are suggestive of mild to moderate anxiety and scores of 45 or higher are associated with mild to moderate depression. Scores of 49 and higher are indicative of severe affective problems.

A relatively new method of assessing secondary trauma has been developed and involves assessing reaction time in response to trauma relevant words. This procedure is called the emotional Stroop or modified Stroop and is based upon the color and word naming work of J. R. Stroop (1935). Stroop found that when a color word such as "red" is printed in red ink, one can more quickly name the ink color than when the word "red" is printed in non-congruent color such as green. Here the task of saying "green" when the underlying word is red, takes longer because there is interference between the desire to name the color and the meaning of the word.

Using a similar approach, the modified or emotional Stroop uses trauma relevant words which are printed in colors and the requirement is to name the colors in which the words are printed. So, for example, a person who was traumatically injured in a car accident will take longer to name the color in which the word "pain" is printed than the color in which the word "rain" is printed. Also, the response time to naming the color of "pain" would be longer for the person who had an accident in comparison to one who was not. The modified Stroop has been used in investigations of secondary trauma, PTSD, anxiety, depression, and other disorders.

In secondary trauma studies of adult children of Vietnam combat veterans with PTSD (e.g., Motta et al., 1997; Suozzi, et al., 2004) it was found that the children had significantly longer response latencies to Vietnam related combat words (e.g., combat, war, Nam, etc.) than children of non-veterans. These differences between groups were not found with standard paper and pencil measures of PTSD and related emotional problems. One of the real values of the modified Stroop is that it fairly impervious to attempts to alter one's responses to appear more or less troubled. This is because the vast majority of examinees have no idea that response time is the variable of interest.

Although the modified Stroop has been shown to be an effective and sensitive tool for assessing secondary trauma in adults and children, the development of appropriate stimuli for specific forms of trauma is time consuming. Additionally there is a lack of cutoffs for Stroop latencies so one doesn't know what magnitude of time delay is associated with what level of pathology. Nevertheless, given that secondary trauma is of lesser intensity than PTSD and is often hard to detect with standard paper and pencil measures, the modified Stroop has proven itself to be a highly effective tool in identifying the presence of this disorder.

Therapeutic Interventions

Before describing therapeutic interventions for PTSD, an important caveat must be considered for anyone who attempts to treat this disorder. Avoidance of stimuli that have any similarity to the trauma situation is one of the DSM diagnostic features of PTSD. The significance of this is that the closer a therapist gets to the relevant material that forms the basis of PTSD, the more likely it is that the patient will engage in avoidance maneuvers and perhaps terminate therapy. Lack of attention to this important issue will often lead to failure among novice therapists, and seasoned therapists as well. The motivation to avoid discussing or revisiting trauma material is so strong that the majority of traumatized individuals will not seek therapy or will terminate therapy as soon as the therapist focuses on the relevant traumatic event. Having developed a trusting relationship, therapists must move forward cautiously and not overwhelm their patients with anxiety. Doing so will typically result in that patient not returning.

Another important issue in treating PTSD is that, despite the menu of symptoms listed in the DSM-IV-TR (2000), alleviating symptoms is only half the battle. People with PTSD often have problems with social isolation, substance abuse, employment problems, and marital and family difficulties. These problems must be addressed in a comprehensive treatment of this disorder and a failure to do so results in incomplete or unsuccessful treatment. Therefore, once some of

see Review on page 27

Accessing the Untouchables: The Touch Points to Change

By Landa C. Harrison, LPC
Senior Project Manager and
Sarah M. Yanosy, LCSW, Director
ANDRUS Sanctuary Institute

Effective treatment of Post-Traumatic Stress Disorder (PTSD) requires helping the trauma survivor find ways of acknowledging the role of past trauma in shaping his or her present experience and creating a vision for the future. Without a roadmap, this seemingly simple task may confound both therapist and client for years, prolonging symptoms and eluding wellbeing. The practice of the S.E.L.F. framework, a pillar of the Sanctuary Model®, as an organizing structure for therapeutic intervention creates a compass for therapists and clients to follow as well as paraprofessionals and family members supporting the client's trauma recovery.

The Sanctuary Model is a blueprint for clinical and organizational change that focuses on building a trauma informed environment through establishment of values, language, theory and practice across an entire organization. A trauma informed environment can only be achieved when a community promotes, above all, the critical and recurrent tasks of safety and recovery (Herman, 1992; Janet, 1976). Sanctuary identifies trauma as a continuum of adversity on which

Landa C. Harrison, LPC

occurrences may be discrete, on-going, and/or cumulative and that includes both tangible and intangible experiences of adversity, such as racism and poverty. Effectively supporting individuals with PTSD means helping them access past events and the emotions that accompany them that are often considered untouchable. It means offering a language that captures both the simplicity and complexity of traumatic experience and turns the untouchable to accessible.

S.E.L.F., an acronym that stands for Safety, Emotions, Loss and Future, is a vital tool for accessing those untouchable events and feelings. S.E.L.F. offers a language for describing challenges and planning interventions. Simply put, the S.E.L.F. framework levels the playing field by moving away from mental health jargon and toward the transformative power of change. Designed to foster clarity through a concise and flexible frame, S.E.L.F is non-linear in nature and focuses trauma survivors on a restorative perspective of hope and belief that a person can imagine a brighter, sustainable future. The idea is pure and organic: utilize an accessible language that eliminates the complex theoretical dogmas of trauma and recovery while empowering people to talk about their ability to heal and recover from their traumatic events. S.E.L.F. offers a sense of hope, which otherwise seems inaccessible, by promoting skill building and mastery in the framework's four components: safety, emotions, loss and future. These natural touch points offer guideposts to explore and resolve grief in a safe, participatory and emotionally contained manner.

The S.E.L.F. framework is comprised of four key concepts, or touch points, that relate to the healing and recovery from trauma. They are:

Safety: How do you stay physically, psychologically, emotionally and morally safe?

Emotions: How do you manage the different emotions that you will feel? How do you support someone who is struggling with anger, sadness, the kinds of symptoms that emerge after exposure to trauma? How do you not let those take you over?

Loss: How do you deal with the loss of function, the loss of friends, and the inevitable loss that you feel when you choose one path over another? How do you manage the process of discomfort around ongoing of self-discovery and evolution?

Future: How do you envision the future when victims of trauma are likely to have a foreshortened sense of future? How do you create a new definition of feeling safe? How do you imagine the ability to trust?

Promoting Recovery through S.E.L.F.

Treatment of trauma survivors is messy. Survivors often have difficulty recognizing and expressing their feelings, lose their positive and loving feelings toward other people or report feeling disconnected in their relationships and friendships. Additionally, individuals may not be interested in activities they once enjoyed; they may not readily remember parts of the traumatic event or even be able to talk about what has happened

see Change on page 32

Review from page 26

the more prominent symptoms of PTSD have subsided, there may then be a need for interventions such as social skills retaining, marital therapy, employment counseling, and substance abuse interventions. In summary, treating PTSD involves establishing a trusting relationship, moving forward with care so that patient does not become overwhelmed and terminate therapy, and making efforts to reconnect with family, friends, and society in general.

There is virtually no research on the comparative efficacy of treatments for secondary traumatization. As indicated earlier, those experiencing secondary or vicarious trauma have symptoms similar to those of primary trauma patients or family members with whom they interact but these symptoms are of lesser intensity. Therefore, therapeutic approaches with those who experience secondary trauma often center around supportive counseling and psychotherapeutic approaches oriented toward the alleviation of anxiety and depression.

While there are over 400 different forms of psychotherapy, and advocates of each of these types might claim that they can be effective in treating PTSD, some of the more common forms of psychotherapy include cognitive-behavioral therapy (CBT), psychodynamic therapy, psychopharmacology, exposure therapy, anxiety management training, and stress management techniques. (Foa & Meadows, 1997). The most commonly used form of treatment today is cognitive-behavior therapy (CBT). The reason for the popularity of this form of treatment is that it has been supported by a large number of sound empirical studies. Virtual Reality Procedures have also been used as well as Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001). Finally, drugs are commonly used in treating PTSD. It is most important to restate that regardless of the form of therapy that is implemented, without a trusting and mutually respectful relationship, little of therapeutic value will take place.

Cognitive Behavior Therapy

Cognitive behavior therapy is a generic descriptor that includes exposure therapy and therapeutic approaches designed to alter dysfunctional patterns of thinking and behaving. Exposure therapy essentially involves inducing patients to confront and not avoid trauma situations that underlie their problems. So, for example, a combat veteran might be asked to describe their trauma situations in great detail and to re-experience associated painful emotions, or to view and listen to real or simulated firefights and other combat scenarios. Exposure can be in-vivo where the patient re-exposes themselves to actual trauma situations in the hope that their fear reactions will eventually extinguish, or imaginal, e.g. to imagine the combat situation in great detail.

Cognitive-behavior therapy involves altering ones thoughts and beliefs with regard to trauma situation and encouraging patients to confront the trauma, either in small steps or all at once (sometimes referred to as flooding or implosive therapy). The dysfunctional beliefs that are addressed are of the nature, "I can't handle this, it is too much for me" or the view that "I cannot overcome my reactions to trauma; nothing will ever change." So cognitive behavior therapy (CBT) makes efforts to alter one's thoughts and behaviors as they relate to the trauma situation. Irrational thoughts such as those above inevitably lead to negative emotional states such as elevated anxiety and depression.

At times therapies are combined. For example, cognitive therapy is combined with exposure therapy or exposure therapy is done within a group format (e.g., Foa et al., 1999; Sutherland, Mott, Williams, Teng & Ready, 2012). Similarly, cognitive therapy might be used with the traumatized veteran and their spouse in order to deal with commonly occurring negative interpersonal sequelae resulting from combat experiences (Fredman, Monson, & Adair, 2011).

Manualized forms of CBT are common. One example is Cognitive Processing Therapy (CPT; Resick, 2001). An initial session involves brief psychoeducation addressing the nature of CPT and PTSD. The next two sessions involve writing and reading about the nature of the traumatic event and why one believes it happened. Here one attempts to identify problematic beliefs about the event and to learn how these beliefs affect the individual's thoughts and feelings. Emphasis is also placed on how thoughts and feelings are connected. Additional sessions are dedicated to learning to challenge one's self-statements and assumptions and to eventually modify dysfunctional and maladaptive beliefs. Remaining sessions involve challenging overgeneralizations about oneself and others in the areas of safety, trust, control, power, self-esteem and intimacy. (e.g., "You can't get close to people. They will eventually hurt you." (Alvarez et al., 2011)

While CPT clearly emphasizes a cognitive viewpoint of PTSD, it could be argued that the majority of other forms of CBT emphasize exposure and reprocessing of trauma material in order to reduce the high levels of anxiety that trauma situations generate. Examples here might include having a rape victim discuss the details of what happened during the rape including the fear, helplessness, and the eventual feelings of hopelessness that the rape generated. By revisiting this disturbing event within the safe and secure confines of the therapist's office, the fear is lessened and a more objective perspective is developed. Another example of exposure would be presenting video and audio stimuli of war to veterans with PTSD. Again, because this trauma material is presented within an environment of safety and support, the raw fear that these stimuli entail begin to diminish and the veteran begins to develop a greater sense of control and a lessening of perceptions of vulnerability as their capability to face the trauma increases.

Another form of intervention that loosely falls into the behavioral or cognitive behavioral domain is aerobic exercise. One of the first studies to specifically evaluate aerobic exercise as an intervention with adults involved a small sample of individuals who had experienced tragic death of a relative or friend, sexual or physical assault, severe auto accident, combat, severe illness, injury, or disease (Manger & Motta, 2005). Results of this study showed that aerobic exercise alone resulted in significant reductions in PTSD, anxiety, and depression.

see Review on page 30

Images from the Bravemind Fully Immersive Interactive Virtual Reality-Based Application Used to Assess and Treat Military Service Members

Virtual Reality from page 15

required as many as 18-20 sessions to achieve a successful treatment response and a significant percentage of SMs dropped out of the study prior to completion. If DCS is effective in accelerating, as well as improving the response to therapy, this could make therapy more appealing, and could enable larger numbers of patients to be successfully treated since fewer sessions would be required.

STRIVE

STRIVE is a natural extension of *Bravemind*. *STRIVE* essentially repurposed and enhanced the assets used for the assessment and treatment of anxiety disorders such as PTSD (via *Bravemind*) into a VR-based capability for preventing such anxiety disorders and improving stress resilience. *STRIVE* achieves this by immersing SMs in virtual environments representative of the stressful experiences they are likely to encounter and then teaching these SMs how to better deal with and cope with these situations such that healthy mental and emotional responses result. The coaching and mentoring processes for *STRIVE* is provided by virtual human characters employing Cognitive Behavior Techniques (CBTs). The use of virtual human characters to effectively serve as a virtual coaches, mentors, and trainers are well documented.

STRIVE allows SMs to develop the resiliency and mental toughness needed to perform well and rapidly recover from high-stress conditions. Through repeated systemic stress exposure and training in coping techniques SM resilience levels can be significantly increased and maintained such that these individuals are less prone to suffering from psychological health issues such as anxiety, depression, and PTSD.

Stress Inoculation Training is associated with the notion that repeated exposure to stressful tasks allows for decreased levels of stress when subsequently exposed to these tasks. This approach has been successfully used for a wide variety of applications. Modern cognitive theory and psychotherapy indicate that emotional reactions result from appraisals of events and not the actual events themselves. As such, there is significant potential for teaching and reorienting the thought processes involved via the appraisal process such that healthier and more resilient emotional reactions result. Via *STRIVE* virtual human characters are being used to provide this training and reorientation process both throughout scenario execution and afterwards during the resilience training phase. Part of the training and reorientation process involves a demonstration and explanation of what happens to the brain and the body whenever stress is experienced, what the major components of resilience are, and what can be done to rapidly recover from stress such as performing various physical and cognitive exercises.

STRIVE also includes the use of stress measures to allow baselines for each SM to be established so that any changes from baseline levels can be readily determined and assessed. Acute psycho-physiological measures of stress are recorded while SMs are engaged both during the stress induction and the resilience training stages. The use of these kinds of measures indicate when a given module should be concluded (e.g., when the stress indicators are high) and when the next module should begin (e.g., when the stress indicators have significantly decreased after resilience training has been performed).

STRIVE also features the use of a range of biomarkers indicating an individual's long-term methods of reacting to stress. One such measure is defined as Allostatic Load (AL). AL is a single index representing the combination of key biomarkers indicative of poor stress response. AL is associated with allostasis; the process by which the body adapts to acute stress in its attempt to maintain stability. AL essentially represents how individuals are affected by stress over the long term; it is not dependent on short term stressors. Higher levels of AL indicate poorer stress responses while lower levels of AL indicate healthier stress responses.

A new index being defined as Allostatic Reserve (AR) is being created to reflect key biomarkers indicative of stress resilience and stress-induced growth. It is anticipated that higher levels of AR will be associated with individuals who tend to handle stress well and rapidly recover from stressful situations and that lower levels of AR will be associated with those who tend not to handle stress well or who tend to recover more slowly from stressful situations.

By establishing a set of indices for stress and stress-resilience, the AL and AR profile of an individual could indicate how well the person might perform in stressful situations, how resilient the individual might be in recovering from these situations, and the resilience training which might be most beneficial to the person to ensure resiliency is maximized.

Conclusion

Technical innovations, such as those being developed by the ICT, will continue to provide novel opportunities for the health and medical communities. Two efforts pioneering these innovations are *Bravemind* and *STRIVE*. *Bravemind* assists individuals suffering from anxiety disorders such as PTSD by gradually immersing them in virtual environments representative of their traumatic experiences. *STRIVE* extends the *Bravemind* technology for use in improving stress resilience and preventing anxiety disorders such as PTSD into what can be thought of as a psychological and emotional obstacle course as a means by which to improve the performance of SMs and allow them to rapidly recover from high-stress situations. Additional information regarding *Bravemind*, *STRIVE*, and other technological innovations being developed by the ICT is available at http://ict.usc.edu/.

Joseph M. Brennan, Jr. works for the U.S. Army Research Laboratory, Human Research and Engineering Division, Simulation and Training Technology Center in Orlando, Florida where he is the Chief Engineer for the Institute for Creative Technologies (ICT) Contract. ICT is a Department of Defense University Affiliated Research Center (UARC) associated with the University of Southern California (USC) which advances the state-of-the-art in immersive virtual reality systems. References used in the development of this article are available by emailing Mr. Brennan at: joe.brennan@us.army.mil.

Mental Health News

Salutes Our Advertisers

For Bringing Their Vital Programs and Services

To the Attention of Our Readers.

In This Way Mental Health News

Is Fulfilling Its Mission

Of Providing A Roadmap to Services

And Improving Access to Care

To Consumers and Families

Throughout New York State

And Beyond!

Review from page 27

Follow-up studies with adolescents and children (Diaz & Motta, 2008; Newman & Motta, 2007) again demonstrated significant reductions in PTSD and related symptoms. It is unknown as to why aerobic exercise would have such positive effects and it is speculated that it might be due to its well-known anxiety reducing properties (Motta, McWilliams, Schwartz, & Cavera, in press).

Regardless of the type of intervention, once these initial steps are achieved, the focus of therapy then moves to addressing more general social, employment, substance abuse, and family functioning issues. When progress is made in these areas, the patient is encouraged to re-evaluate themselves and their view of the future with the hope of developing more positive perspectives.

Virtual Reality and EMDR

Among the various forms that exposure therapy may take, Virtual Reality therapy (VR) is an approach that has been used in the treatment of PTSD. When using VR, headgear is worn that allows participants to look around and as they do so, the scenery changes as if they were actually scanning the environment. Vietnam veterans, for example, have been exposed to war scenes involving enemy combatants, helicopters, gunfire, and explosions (Rothbaum, Hodges, Ready, Graap, & Alarcon, 2001). Data from such studies indicate that there are significant reductions in PTSD following the use of VR.

After an initial burst of enthusiasm for using this approach, a fading of interest occurred which may have been due to the expense of the equipment and the even greater cost of producing the software underlying the electronic scenery. As technology has advanced prices have been reduced but VR is still a somewhat inconvenient procedure to employ especially when one treats a variety of traumas. Another issue that has reduced enthusiasm for the VR procedure is that there is not an abundance of evidence that VR works any better than other forms of exposure. Its real value in treating war related PTSD is that re-exposing a patient to actual war scenarios is, in most cases, neither possible nor desirable. Nevertheless, VR does play a role in treating PTSD especially when other forms of exposure are not possible.

Like Virtual Reality therapy, Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 2001) has also been used in the treatment of PTSD, however the EMDR approach has generated a good deal of controversy. This controversy stems not from the issue of whether or not EMDR can be effective but rather has to do with the hypothesized mechanisms by which the technique is said to work. The EMDR approach maintains that trauma experiences may overwhelm cognitive and neurological mechanisms. This results in memories of the trauma being inadequately processed and then stored in isolated memory networks. EMDR is said to facilitate access to those networks. Typically traumatized clients engage in therapist-directed lateral eye movements, alternate hand-tapping, or listening to bilateral auditory tones and while doing this, they also imagine their unique trauma in detail. This dual process of imagining the trauma while engaged in one of the above activities is said to allow the trauma memory to now be processed in an area that is more readily accessible and thereby treatable. Thus, it would appear that an information-processing model is the basis of this form of intervention.

A number of researchers (e.g. Herbert et al., 2000) report that there is no evidence to support the information processing model and that what accounts for the ostensible efficacy of EMDR is simply exposure. It is argued that because patients are asked to imagine the trauma situation in detail as part of the EMDR procedure, the exposure rather than the inferred information processing, accounts for change. One might also argue that by engaging in saccadic eye movements or finger tapping, the patient is somewhat distracted from an intense focus only on their trauma and in being so distracted they become less avoidant and can thereby more readily deal their trauma. From these perspectives both VR and EMDR appear to have a common rationale for their claims of efficacy: exposure. Exposure has an abundant empirical basis for its efficacy and so EMDR and VR can be seen as different approaches for providing this important component of treatment.

Drug Treatment of PTSD

Psychopharmacological treatments for PTSD typically center on an alleviation of the symptoms of PTSD but are not considered a primary method for treating this disorder. In addition, veterans whose symptoms have lasted for years do not appear to significantly benefit from drug treatment (Friedman, Marmar, Baker, Sikes, & Farfel, 2007). The utility of medications in treating PTSD is often that they may be able to reduce the levels of anxiety and depression to such a degree that the patient is no longer as avoidant of treatment as he or she was previously. The evidence base for drug treatments is most supported in studies of selective serotonin reuptake inhibitors (SSRI's). Two medications, Sertraline (Zoloft) (Brady et al. 2000) and Paroxetine (Paxil) have FDA approval for treatment of PTSD.

SSRI's increase the neuro-availability of serotonin, which is important in regulating mood, sleep, anxiety, and other bodily functions. The use of SSRI's with PTSD typically results in only modest effect sizes in comparison to those achieved with psychotherapy (Keane, Marshall, & Taft, 2006). It is contra-indicated in those PTSD patients who may have a co-morbid bipolar disorder. In such cases SSRI's have been known to precipitate episodes of mania. Of the newer anti-depressants, Venlafaxine (Effexor) has been recommended as a first line treatment for PTSD by the Veterans Administration (VA)/Department of Defense (DoD). This medication is a serotonin reuptake inhibitor at lower dosages and at higher dosages acts as a combined serotonin and norepinephrine reuptake inhibitor. Prazosin (Minipress) is also a medication used specifically for disturbing nightmares associated with PTSD. This medication is said to block adrenaline.

Mood stabilizers are preferred in situations where there is a bipolar disorder that is co-morbid with PTSD, especially in situations where SSRI's are found to precipitate mania. Carbamazepine (Tegretol), Divalproex (Depakote), Lamotrigine (Lamictal), and Topiramate (Topimax) are common mood stabilizers. All such medications should be used with care due to potentially serious side effects such as agranulocytosis (severe lowering of white blood count), liver toxicity, skin rash, sedation, and dizziness, among others.

Antipsychotics have also been used to treat PTSD and they impact the dopaminergic and serotonergic systems. Risperidone (Risperdal) is one such medication. These drugs have been used when a psychotic disorder is co-morbid with PTSD. However recent VA/DoD guidelines do not recommend them as their side effects often exceed their utility. All antipsychotics have been associated with an increased likelihood of sedation, sexual dysfunction, postural hypotension, cardiac arrhythmia, and sudden cardiac death.

While PTSD is an anxiety disorder, anxiolytics like the Benzodiazepines must be used with discretion. Two problems emerge with these medications and they are addiction and disinhibition. Examples of these drugs include Lorazepam (Ativan), Clonazepam (Klonopin), and Alprazolam (Xanax).

While psychopharmacological treatments have a place in dealing with the complex and debilitating symptoms of PTSD, it is best to view their role as adjuncts to psychotherapeutic approaches. Psychotherapeutic approaches emphasize the fact that the traumatized person must eventually learn to function in their world and to view that world and themselves in a more objective and positive light Medications alone will not bring about these critical objectives. Nevertheless, medication may serve as a facilitator in reaching these important therapeutic goals.

Summary

PTSD, like most forms of mental illness, brings with it a unique set of human torments. Aside from its debilitating symptoms, it often precipitates a negative, suspicious, and diminished sense of self and a dark view of the present and the future. It contains within its diagnostic criteria the especially problematic feature of avoidance. This tendency to avoid thoughts, feelings, and images that remind the PTSD sufferer of their trauma significantly interferes with treatment. While many of those who suffer mental illness refuse treatment as a way of denying their problems, PTSD is the only disorder that has this feature as one of its diagnostic criteria. For this reason, therapists who treat PTSD must have a delicate and sensitive appreciation of avoidance tendencies and must learn to tread lightly when dealing with relevant therapeutic issues. Manualized treatments, while helping the therapist develop a scientifically based treatment framework, are no substitute for the art of therapy: the gut sense of how quickly to move forward or to not do so (Wampold, 2001).

Secondary traumatization adds an additional layer of complexity in that trauma reactions can and do spread contagiously to therapists, family members, and anyone else who has close and extended contact with the trauma victim. Thus, therapists who treat this disorder must not only have excellent capabilities and awareness of one's own vulnerability, but must also function as something of disease control specialists. They must intervene to stem the spread of this disorder to others through secondary traumatization. In most cases, by the time the PTSD sufferer comes to the therapist's office, the disorder has already spread to others and the therapist will now have an abundance of problems to deal with. A further challenge for therapists is that while new assessment approaches to secondary trauma are beginning to emerge, research on effective therapeutic approaches are virtually non-existent.

Cognitive behavior therapy, including exposure therapy, and the use of medications are presently the mainstays of treatment. The non-medical approaches play the more dominant role in terms of attaining a comprehensive treatment and not just a suppression of symptoms. Of course, the avoidance and negativism that is characteristic of PTSD results in both psychotherapy and pharmacotherapy being often unavailable to the traumatized patient. Given the complexities involved in treatment, a good deal of further research and skillful therapist training is needed to deal effectively with PTSD and secondary trauma.

The important inclusion of PTSD in the Diagnostic and Statistical Manual of Mental Disorders starting in 1980 has brought about more treatment funding and other resources for dealing with this disorder and because of this, diagnostic and treatment approaches have continued a slow but continuing advance. Therefore it is reasonable for both therapists and researchers to have at least guarded optimism for future effective interventions for this disorder. Progress is clearly being made but there are many hurdles to be overcome in treating this particularly life altering and self-negating form of mental illness.

For a full list of references contained in Dr. Motta's article you may Email him at: Robert.W.Motta@hofstra.edu.

Online Toolkit Aims to Support Mental Health Providers Serving Veterans in the Community

By the United States Department of Veterans Affairs

The Department of Veterans Affairs has developed a new online Community Provider Toolkit (www.mentalhealth.va.gov/communityproviders) aimed at delivering support, therapeutic tools, and resources to community providers treating Veterans for mental health concerns.

"Many Veterans seek mental health care at VA, yet many also choose to go to providers in their community," said Secretary of Veterans Affairs Eric K. Shinseki. "VA is committed to helping Veterans wherever they may seek care. This toolkit will enable those community providers who treat Veterans to better understand the specific issues Veterans face and help them access VA resources."

The goal of the Community Provider Toolkit is to further enhance the delivery of mental health services to Veterans through increased communication and coordination of care between community providers and VA. It not only provides information about accessing, communicating with, and, if needed, making referrals to VA, but also provides effective tools to assist Veterans who are dealing with a variety of mental health challenges. The Community Provider Toolkit also includes sections intended to increase providers' knowledge about military culture.

On Aug. 31, President Obama issued his historic Executive Order to improve mental health services for Veterans, Service members and military families. As directed in the Executive Order, VA is hiring 1,600 new mental health professionals and 300 support staff. The Executive Order also directed a 50 percent increase in the staff of the Veterans Crisis line.

Last year, VA provided quality, specialty mental health services to 1.3 million Veterans. Since 2009, VA has increased the mental health care budget by 39 percent. Since 2007, VA has seen a 35 percent increase in the number of Veterans receiving mental health services, and a 41 percent increase in mental health staff.

VA provides a comprehensive continuum of effective treatments and conducts extensive research on the assessment and treatment of PTSD and other mental health problems. Those interested in further information can go to www.mentalhealth.va.gov or www.ptsd.va.gov to find educational materials including courses for providers and best practices in mental health treatment. They can also learn more about the award-winning VA/DoD PTSD Coach Mobile App, which provides education, resources, and symptom monitoring and management strategies.

FAST-PS: A New Initiative for Developing Novel Treatments for Psychosis and Other Mental Disorders

By the National Institute of Mental Health (NIMH)

The National Institute of Mental Health will fund research at Columbia University Department of Psychiatry and New York State Psychiatric Institute (NYSPI) to speed the development of effective psychotropic agents and improve treatment for those suffering from mental illnesses

There is a serious crisis in drug development for mental disorders. The numbers of potential new compounds in the research pipeline has dropped precipitously in the past decade. The expense of development and lack of progress has led a number of pharmaceutical companies to curtail or cease drug development for brain disorders. This lack of development and innovation seriously impacts the future of treatment for those suffering the burden of psychosis and other mental disorders.

Recently, the National Institutes of Mental Health (NIHM) awarded researchers at the Research Foundation for Mental Hygiene (RFMH) at the Columbia University Department of Psychiatry and New York State Psychiatric Institute (NYSPI) a major contract to implement the NIMH FAST-PS Initiative. The FAST-PS Initiative is designed to rapidly and efficiently identify and test the most promising new compounds as treatments for psychotic disorders. This new paradigm in experimental medicine studies, termed 'fast-fail', entails conducting 'proof of concept' trials using biomarkers to provide early evidence of mechanism of action and clinical efficacy. The contract, if fully executed, will provide up to $9M in funding over the next 3 years.

The research team, known as the Academic Consortium for Early Stage Drug Discovery in Psychosis (ACES-DDP), will be led by Jeffrey A. Lieberman, MD, Chairman of Columbia University Department of Psychiatry and Director of NYSPI. Daniel C. Javitt, M.D., Ph.D. will serve as co-PI and Director, for the Columbia performance site; Ragy Girgis, M.D. and Joshua T. Kantrowitz, M.D. will serve as co-investigators. Early stage clinical trials will be performed in collaboration with Serge Cremers, Pharm.D., Ph.D. and the staff and facilities of the Irving Institute for Clinical and Translational Research at Columbia University Medical Center.

In addition to the Columbia/NYSPI site, the ACES-DDP consortium will involve experts in schizophrenia research and five collaborating institutions including Robert Buchanan, MD, Maryland Psychiatric Research Center (MPRC); Cameron Carter, MD, University of California – Davis; Donald Goff, MD, New York University Langone Medical Center/Nathan Kline Institute (NKI); John Krystal, MD, Yale University; and Stephen Marder, MD, University of California – Los Angeles which will serve as performance sites. State of the art brain imaging and electrophysiological technology will be used to assess the effects of compounds selected for investigation in healthy volunteers and those suffering from serious mental disorders.

"FAST-PS is a badly needed initiative by the NIMH to spur innovative drug development at a time when the pharmaceutical industry has retreated from the challenge of meeting overwhelming unmet clinical needs," said Jeffrey Lieberman, MD, who will lead this project.

"My congratulations to Dr. Lieberman for winning this crucially important treatment development contract. The promise of scientific progress to lessen the pain and costly disability associated with mental illness has not yet been met. I commend NIMH for recognizing this and creating this mechanism to slow the time lag between development of new scientific knowledge and the availability of safe and effective treatments. The fact that two New York State Office of Mental Health Research Institutes will participate shows the significance of the work being performed at these centers. This contract awarded by NIMH, to fast-track the most effective psychotropic agents through the development process, will not only deliver much needed psychiatric medicine to those who need it most but will also ensure that New York State remains a leader in the field of mental health innovation." said Commissioner Michael Hogan, New York State Office of Mental Health.

Columbia Psychiatry is ranked among the best departments and psychiatric research facilities in the nation and has contributed greatly to the understanding and treatment of psychiatric disorders. Located at the New York State Psychiatric Institute on the NewYork-Presbyterian Hospital/Columbia University Medical Center campus in northern Manhattan, the department enjoys a rich and productive collaborative relationship with physicians in various disciplines at Columbia University's College of Physician's and Surgeons. Columbia Psychiatry is home to distinguished clinicians and researchers noted for their clinical and research advances in the diagnosis and treatment of depression, suicide, schizophrenia, bipolar and anxiety disorders, eating disorders, and childhood psychiatric disorders. Columbia Psychiatry's extraordinary scientific base is supported by more federal grants than any other psychiatry department in the nation.

Visit columbiapsychiatry.org for more information, and follow us on Twitter @ColumbiaPsych.

Person from page 20

negative aftermath include: lack of network supports; feelings of aloneness; emotional unavailability; disbelief, stigmatizing, shame, shunned; secondary victimization; conspiracy of silence; lack of treatment; and ineffective coping skills. Those who exhibit *positive healing* include: accepting the reality of the experience; psychological debriefing; recognition and expression of feelings; revealing not concealing; rediscovering self, family, and friends; allowing network acceptance and support; being of service to others; and rejoining and reinvesting in life.

The road to recovery may include, but is not limited to, the following treatments/ approaches:

- Cognitive Behavior Therapy: integrating emotionally disassociated/distorted thoughts

- Acceptance and Commitment: recognition and moving forward

- Stress Inoculation Training (SIT): exposure to lesser stressors to build or regain resiliency

- Breathing and Relaxation Techniques: focused breathing/activities to decrease anxiety

- Cognitive Processing Therapy (CPT): reinforcing strengths and teaching strategies

- Review/revisit/restructure: confront, challenge, and control (from victim to survivor)

- Autogenic training: a form of self hypnosis that relaxes and utilizes imagery

- Meditation: learning to free the mind of thought for increasing periods of time

- Anger Management: developing internal controls and coping mechanisms

In summary, PTSD symptoms are normal responses by normal people to abnormal situations. The recovery and resumption of "normalcy" is highly dependent upon the multi-variant factors listed above. Too often, a remarkable recovery of a trauma survivor may be portrayed in a way that may cause others who are not faring as well in similar circumstances to feel incapable of healing.

References

Matsakis, Aphrodite,1994. Post-Traumatic Stress Disorder A Complete Treatment Guide. Oakland, CA: New Harbinger Publications.

Schiraldi, Glenn R., 2000. The Post-Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery, and Growth. Lincolnwood, IL: Lowell House

Change from page 27

and how they feel. Shifting these barriers to memory and feeling is critical for recovery, and these shifts only happen through relationship. Unfortunately, the healing journey begins with an unwanted conflict: relationship is at the core of healing from traumatic experience while relational damage is likely at the core of the individual's problems. (Bloom, Harrison, Yanosy, 2012). By attending to the need for *safety*, building skills for managing *emotions*, grieving the *losses* created by the trauma and creating a vision for a different *future*, those who are in a therapeutic, caring or supporting role to the survivor can partner with each other and the survivor to build the bonds of healing relationships.

Accessing the Touch Points of S.E.L.F.

Utilizing the S.E.L.F. framework establishes a collaborative structure for creating agreed upon expectations, boundaries and action plans that promote meaningful change.

Given the intricate nature and turbulent effects of trauma on the survivor, PTSD intervention and treatment must come from the conviction that people are not "sick" but instead, they are injured (Bloom, 1997). In making this paradigm shift, service providers, family and friends are able to create space to value and respect an individual's experience, thus allowing him or her to be in control as he or she learns what it means to truly understand the impact of the trauma.

Because S.E.L.F. is a non-linear framework, using it effectively requires willingness to rearrange its order. Often, it makes sense to start with future (where we hope to be) and work backwards from there, considering concerns and possible interventions related to safety, emotions and loss. For instance, it may be hard for a survivor to invest in skill building around emotion management if he or she does not have a sense of future. Sometimes loss is the most reasonable starting point for trauma work. Unsafe behaviors are frightening, so eliminating those often becomes the paramount goal for those working with a survivor. These efforts may prove futile if unaddressed and unresolved grief is driving those unsafe behaviors. Equally important is the knowledge that S.E.L.F. recovery work does not happen in stages that are completed, but may require weaving in and out of the four touch points continually revisiting them in new ways over the course of healing.

Touch from page 22

made processing possible once she was soothed, comforted and reassured – once she was brought back into relationship. Treatment could then proceed with Mandi both in terms of the touch intervention used and the trust that gradually developed from it with the staff. Touch as a way to alleviate stress and inhibit reactivity provided the foundation for further treatment. Instructing her foster parents in the use of safe, healing touch, knowing how important it was to Mandi, became the basis for her successful return home.

Because the misuse of touch in physical and sexual abuse has harmful effects, risk prevention has tended to dominate the clinical stage at the cost of clinical effectiveness. "No touch" policies have been instituted by many agencies to guard against potential abuse, but more pointedly to guard against the threat of litigation. This is done without considering that more harm may be done to a child by perpetuating early touch deprivation and how a sexually or physically abused child will learn the difference between healthy and harmful touch. What Wellspring has done is take a pro-active approach to the use of touch in treatment that combines an in-depth understanding of its integral role in development with ethical and practical guidelines for safe and sound practice.

The use of touch in treatment is applied not only to traumatized, attachment resistant children like Mandi, but to traumatized adolescents and young adults as well. The use of safe, healing touch at Wellspring is permission based, treatment related and trauma informed. It stems from ongoing assessments of each client and family, which includes not only an assessment of sexual abuse, but the assessment of hyper and hypo-sensitivity to touch that can differentiate sensory integration and sensory modulation problems from problems with attachment. Equipped with this information, staff is trained with ongoing supervision in the different levels of safe, healing touch, ranging from supportive touch to permission based and clinically authorized nurturant holdings designed to fill in developmental gaps. Stress reduction for clients suffering from PTSD is a by-product of this approach.

Within our adolescent residential program, for example, and based upon mutual agreement, parents who were withholding of touch based on their own parenting, are encouraged to hold their children once they are able to recognize its importance for their child's health. This invariably has had a positive effect in helping families to develop healthy, affectionate and supportive relationships, which in turn has facilitated successful returns home.

When these relational and "bottom up" modes of processing are woven into the fabric of an intensive multi-modal treatment program, which is anchored in turn by individual, group and family therapy, they add the necessary means and power to address and heal traumatic residues from the past.

** Names have been changed to protect privacy.*

Many Aspects from page 10

Such studies highlight the need for further psychoeducation and outreach to minimize stigma and promote treatment engagement in military personnel and marginalized populations.

Despite these obstacles, significant strides continue to be made in the refinement, dissemination, and implementation of effective treatments for PTSD. Utilization of innovative technologies such as VR and initiatives by both the Departments of Defense and Veterans Affairs to rollout two evidence-based treatments, prolonged exposure and cognitive processing therapy, represent promising directions in the fight against PTSD. Exciting developments such as these may benefit those who have not responded to traditional treatments and ensure that greater numbers of individuals have access to empirically supported treatments. Such efforts offer new hope of providing relief to the approximately 7% of Americans who suffer from PTSD.

The Program for Anxiety and Traumatic Stress Studies is a specialized program within Weill Cornell Medical College's Department of Psychiatry. Led by JoAnn Difede, Ph.D., a pioneer in the field of anxiety disorders, the Program for Anxiety and Traumatic Stress Studies offers a state of the art approach to patient care that brings innovation to tried-and-true therapeutic techniques. For many years the program has provided psychological consultation to the New York Presbyterian Hospital Burn Center and has implemented a number of research-based clinical interventions designed specifically for individuals suffering from burn injuries, terrorist attacks, motor vehicle accidents, interpersonal violence, and life threatening illnesses. Our work with the Burn Center naturally lead to relationships with the FDNY and disaster rescue and recovery workers, because employees of these groups are treated for work related injuries at the NYPH Burn Center. Through our work with these groups, the Program for Anxiety and Traumatic Stress Studies has become recognized as an unparalleled institution in the treatment of anxiety disorders.

The program is currently conducting a national clinical trial for the treatment of combat-related PTSD in Veterans who have served in Iraq or Afghanistan, with funding from the Department of Defense. The study involves the first-line treatment for PTSD, imaginal exposure therapy, and an innovative form of exposure therapy enhanced with virtual reality. Potential participants can enroll in Long Beach, CA, Westchester or New York, NY, or Bethesda, MD, and may be eligible for up to $350 reimbursement. To learn more about this program or to schedule an appointment, call (212) 821-0783.

Considerations from page 4

as well as paired associations related to substance misuse, are part of what trigger and maintain cravings for substances, and perpetuate cycles of relapse and misuse. Implementing a model of care that can accomplish the above goals is essential to address both the symptoms of PTSD and substance misuse that many service members present with. Evidence-based therapies for PTSD (Exposure Therapy, Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing), expressive therapies, equine-assisted psychotherapy, and Brainspotting can all play a role towards this end.

Domain Four - Integrating family members into the fabric of treatment for wounded warriors: When an individual joins the military, their entire family joins as well. The service and sacrifices of our Nation's military is carried squarely on the backs of our military families, and when a service member is suffering from acute behavioral health issues, the family suffers as well. Many family members of wounded warriors are tired from being in a caretaking role, are confused and do not have a clear understand of what their family members is truly suffering from or dealing with, and are in need to support themselves as they try to keep their families intact. Finding ways to have families members take an active part in the treatment of their service member, and ways to provide education and support to family members so that they and the entire family is more resilient, is truly necessary to maximize inpatient and outpatient treatment gains. An example of a local, creative collaboration to expand inpatient treatment to include the military family is the Family Reintegration Program. Aligning the missions of the Military Wellness Program at Holliswood Hospital and Hope for the Warriors (a national non-for-profit organization dedicated to supporting wounded warriors and their families), the Family Reintegration Program brings family members of warriors in treatment at Holliswood Hospital to New York free of charge to take part in a four-day intensive treatment workshop. Couples/family therapy, education about PTSD and TBI, family support groups, and respite care for family members are all parts of the program week. This integrative approach with regards to the family allows us to treat a service member in context of his/her support system, improving the chances that treatment gains are maintained and maximized within a more resilient and informed family system.

Domain Five - Integration of a traditional inpatient treatment with trauma processing therapies, expressive arts therapies, equine therapy, alternative therapies (acupuncture/yoga) and promotion of peer support: True integrative treatment involves the creative and evidence-based amalgamation of multiple treatment modalities during the inpatient treatment experience. Overhauling a traditional inpatient treatment program in a way that promotes the coalescence of exposure-based therapies with creative arts therapies (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Collie, Backos, Malchiodi, & Spiegal, 2006; Johnson L. 2008); and promotes peer support and peer engagement, leads to a higher level of treatment success, as well as a dissolution of the stigma and resistance typically associated with being in an inpatient treatment facility. Ensuring the coordinated application of multiple treatment paradigms across disciplines and clinicians (as opposed to a haphazard, disconnected approach where "more" does not necessary equate with "better) is key to approaching the individual treatment needs and preferences of each service member who comes for care. Understanding how to "layer" and phase treatment across both verbal and non-verbal modalities is also a prime consideration to be guided by an integrated treatment team.

Conclusion

The complex behavioral and emotional difficulties faced by many of our service members and veterans, exacerbated by prolonged exposure to deployment and combat stress, require integrative and adaptive treatment models to address issues related to PTSD, substance misuse, and other mental health needs. The Military Wellness Program at Holliswood Hospital takes an integrative treatment approach across multiple domains to treat service members, and serves as a model for integrated treatment of co-occurring disorders. This model can be adapted for use in an outpatient setting, and indeed one such replication is currently being developed at River Hospital in Alexandria Bay, New York to support soldiers at Fort Drum, New York with an intensive partial hospitalization program.

We all have a civic responsibility to support our service members, veterans, and their families in return for the service and sacrifices they all make on our behalf. Veterans, National Guard members and Reservists, and military families live in our communities and they rely on us to provide them with care. Cultivating an understanding of the unique experiences of those who serve, and learning about how best to support them in their recovery from mental health difficulties, allows one to best be prepared to assist them in an appropriate way if they come to us for care.

Dr. Michael DeFalco is the Program Director of Adult and Military Services at The Holliswood Hospital and Director of their Military Wellness Program. He is also the Education Chair of the Veterans Mental Health Coalition of New York City and sits on their Steering Committee. He received his doctoral degree in clinical psychology from Long Island University/ C.W. Post campus, where he specialized in the diagnosis and treatment of persons suffering from serious and persistent mental illness. Dr. DeFalco has worked for over ten years providing treatment and developing treatment programs for children and adults affected by traumatic stress, depression, and other mental health issues. His current area of specialties include the treatment of Posttraumatic Stress Disorder and other disorders related to experiencing traumatic events, as well as geriatric psychiatry and addictions treatment. Dr. DeFalco is active in community education and he maintains an active private practice in Queens and Nassau Counties.

Tara Bulin, LMSW is a founder of The Military Wellness Program at Holliswood Hospital, and a Program Director on Holliswood's Adult Service. Ms. Bulin has extensive experience working with individuals recovering from the effects of traumatic stress. She is a doctoral candidate at the Adelphi University School of Social Work, and she maintains an active private practice in Nassau and Suffolk counties.

Any inquiries or correspondence regarding this article should be directed to Dr. Michael DeFalco at mdefalco@libertymgt.com.

References

Carlson, J., Chemtob, C.M., Rusnak, K., Hedlund, N.L, & Muraoka, M.Y. (1998). Eye movement desensitization and reprocessing (EMDR): Treatment for combat-related post-traumatic stress disorder. Journal of Traumatic Stress, 11, 3-24.

Collie, K., Backos, A., Malchiodi, C., & Spiegal, D. (2006). Art therapy for Combat-related PTSD: Recommendations for research and practice. Art Therapy: Journal of the American Art Therapy Association, 23, 157-164.

Cook, A., et al., (2005). Complex trauma in children and adolescents. Psychiatric Annals, 35, 390-400.

Fisher, J. (November, 2000). Addictions and trauma recovery. Paper presented at the International Society for the Study of Dissociation.

Johnson L. 2008. A place for art in prison: Art as a tool for rehabilitation and management. Southwest Journal of Criminal Justice 5,100-120.

RAND Study (2011). A Needs Assessment of New York State Veterans- Final Report to the New York State Health Foundation. Retrieved on October 21, 2012 from : http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR920.pdf

RAND Study (2008). Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery. Center for Military Health and Policy Research.

Siegel, D.J. (1999). The Developing Mind: Toward a Neurobiology of Interpersonal Experience. New York, New York: The Guilford Press.

van der Kolk, B.A. (2005). Developmental trauma disorder: Toward a rationale diagnosis for children with complex trauma histories. Psychiatric Annals, 35, 401-409.

van der Kolk, B.A., et al. (February, 2009). Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V. Retrieved on April 1, 2010 from: http://www.traumacenter.org/announcements/DTD_NCTSN_official_submission_to_DSM_V_Final_Version.pdf

White House Press Release (2012). Fact Sheet: President Obama Signs Executive Order to Improve Access to Mental Health Services for Veterans, Service Members, and Military Families. Retrieved October 21, 2012 from : http://www.whitehouse.gov/the-press-office/2012/08/31/fact-sheet-president-obama-signs-executive-order-improve-access-mental-h

Mental Health News 2013/2014 Theme and Deadline Calendar

Spring 2013 Issue:

"Moving the Mental Health System Towards a Person Centered, Recovery Oriented Approach "

Deadline: January 23, 2013

Summer 2013 Issue:

"Mind Over Body: Understanding and Treating Eating Disorders"

Deadline: April 23, 2013

Fall 2013 Issue:

"Housing and Employment: How Are We Doing?"

Deadline: July 23, 2013

Winter 2014 Issue:

"Living With Emotional and Physical Pain"

Deadline: October 23, 2013

To Submit an Article or Advertisement Call Us Today: (570) 629-5960
Or Email: iraminot@mhnews.org

Older Veterans from page 8

advocates maintain that it cannot do the whole job.

The fact of the matter is that most veterans do not use the VA. (According to the Veterans' Health Council, almost 70% of veterans do not use the VA for their health care). There are many reasons for this—limited eligibility, not being in priority populations, distance to VA centers, dissatisfaction with service in some facilities, etc.

But it's not just inadequate capacity and resources in the VA that keeps many veterans away. Many have returned to civilian life, to work and family, and want to get their health care from local health and mental health providers as they generally did before they went into the military. Unfortunately, many of these providers are simply not prepared to deal with the special issues that older adults bring to them let alone the special issues of older veterans.[25]

Conclusion

Although virtually all of the growing concern about the emotional struggles of veterans has focused—quite understandably—on those returning from Iraq and/or Afghanistan, in fact a majority of veterans are over 60 and from prior periods of history. They too need and deserve attention to their mental health needs.

In addition to increasing the pace of expansion and improvement of the VA's mental health services, efforts need to be made to insure that older veterans as well as veterans of current wars benefit, including:

· Outreach to older veterans designed to overcome the stigma, which is a barrier to the use of services that are available

· Increased support and training for primary care and mental health providers in the community regarding the culture and special needs of older veterans

· Enhanced support for family caregivers.

Most importantly we need to acknowledge, thank, and honor our older veterans for their service and sacrifice and assure them that our nation will stand by them throughout their lives.

Michael B. Friedman teaches at Columbia University's schools of social work and of public health. He is the co-founder of the Veteran's Mental Health Coalition of NYC and the Geriatric Mental Health Alliance of New York. He can be reached at mbfriedman@aol.com.

Ashley Milco, a student at Columbia University School of Social Work, provided research assistance for this article.

Footnotes

1. Kleinman, A. "Chapter 2: Winthrop Cohen" in *What Really Matters: Living A Moral Life Amidst Uncertainty and Danger*. Oxford University Press, 2006. http://www.oup.com/us/catalog/general/subject/Anthropology/SocialCultural/?view=usa&ci=9780195331325

2. National Center for Veterans Analysis and Statistics. "Veteran Population Projections: FY 2000 to FY 2006." December 2010. https://www.va.gov/vetdata/Veteran_Population.asp

3. VA's National Registry for Depression http://www.va.gov/health/NewsFeatures/20110624a.asp

4. U.S. Department of Veterans Affairs. "One In Ten Older Vets Is Depressed" http://www.va.gov/health/NewsFeatures/20110624a.asp

5. Durai, et al. "Exposure to Trauma and Posttraumatic Stress Disorder Symptoms in Older Veterans…". *Journal of the American Geriatrics Society*, June 2011. http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2011.03407.x/abstract

6. Rosenberg, T. "For Veterans, A Surge of New Treatments for Trauma" *The New York Times*, September 26, 2012 http://opinionator.blogs.nytimes.com/2012/09/26/for-veterans-a-surge-of-new-treatments-for-trauma/

7. Shane L. "Retirement May Unleash PTSD Symptoms in Vietnam Vets" in *Stars and Stripes*, October 15, 2012. http://www.stripes.com/news/retirement-might-unleash-ptsd-symptoms-in-vietnam-veterans-1.180888

8. Trief, P. M. "Post-traumatic Stress Disorder and Diabetes: Co-Morbidity and Outcomes in a Male Veterans Sample" in Journal of Behavioral Medicine, 2006 http://www.springerlink.com/content/x254m61214208713/2

9. Wood, Matt. "Crunching The Numbers on the Rate of Suicide Among Veterans" in *Science Life*, April 27, 2012. http://sciencelife.uchospitals.edu/2012/04/27/crunching-the-numbers-on-the-rate-of-suicide-among-veterans/

10. Glantz, A. "Suicide Rates Soar Among World War II Vets" in *The Bay Citizen* November 11, 2010 http://www.baycitizen.org/veterans/story/suicide-rates-soar-among-wwii-vets/

11. Krishnan, L. et al. "Prevalence of Dementia among Veterans Affairs Medical Care System Users" in Dementia and Geriatric Cognitive Disorders, 2005.

12. Qureshi SU, et al. "Greater prevalence and incidence of dementia in older veterans with posttraumatic stress disorder." In *Journal of the American Geriatrics Society*, September 2010. http://www.ncbi.nlm.nih.gov/pubmed/20863321

13. Sagon, C. "Older Vets With Posttraumatic Stress May Face Greater Risk of Dementia" in *AARP Bulletin* September 3, 2010. http://www.aarp.org/health/conditions-treatments/info-09-2010/older_veterans_with_posttraumatic_stress_may_face_greater_risk_of_dementia.htm

14. Yaffe K., et. al "Posttraumatic stress disorder and risk of dementia among US veterans." *Archives of General Psychiatry*, June 2010. http://archpsyc.jamanetwork.com/article.aspx?articleid=210821

15. Bass, D. et al. "Negative Caregiving Effects Among Caregivers of Veterans With Dementia". *American Journal of Geriatric Psychiatry*, March 2012. http://scholar.qsensei.com/content/1s9005

16. VA. "Aging Veterans and Post-Traumatic Stress Symptoms". *Information on Trauma and PTSD. 12/20/2011* http://www.ptsd.va.gov/public/pages/ptsd-older-vets.asp

17. Thorp S., et al. "Prolonged Exposure Therapy for Older Veterans" *American Journal of Geriatric Psychiatry,* March 2012. http://www.ncbi.nlm.nih.gov/pubmed/22273763

18. National Alliance on Mental Illness. "Depression and Veterans Fact Sheet". October 2009. http://www.nami.org/Template.cfm?Section=Depression&Template=/ContentManagement/ContentDisplay.cfm&ContentID=88939

19. Burnett-Ziegler, et al. "Depression Treatment in Older Adult Veterans". *American Journal of Geriatric Psychiatry,* March 2012.

20. The White House. "Executive Order: Improving Mental Health Services for Veterans" http://www.whitehouse.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service. August 31, 2012.

21 Katz, I. "Geriatric Psychiatry in the Department of Veterans Affairs: Serving the Needs of Aged and Aging Veterans" in *The American Journal of Geriatric Psychiatry*, March 2012

22. Karlin, B. and Zeiss, A. "Transforming The Mental Health Care of Veterans in the Veterans Health Administration" in *Generations*, Summer 2010. http://www.highbeam.com/doc/1P3-2262823451.html

23. Abramson, L. "VA Struggles To Provide Vets With Mental Health Care" *National Public Radio. April 25, 2012.* www.npr.org/2012/04/25/151319599/va-struggles-to-provide-vets-with-mental-health-care

24. VA. "Veterans Health Administration: Review of Veterans Access to Mental Health Services" April 23, 2012. http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf

25. Karlin, B. and Zeiss, A. "Transforming The Mental Health Care of Veterans in the Veterans Health Administration" in *Generations*, Summer 2010. http://www.highbeam.com/doc/1P3-2262823451.html

Subscribe to Mental Health News

Yes! **I want to receive each Quarterly issue by Mail**

- ☐ Student ($20/year) School/Program _____
- ☐ Individual/Family ($40/year)
- ☐ Professionals ($50/year)
- ☐ Group - 50 Copies Each Issue ($300/year)

Give a Gift of Hope
Order a Gift Subscription for Someone in Need

Name & Title: _____

Address: _____

_____ Zip: _____

Phone: _____ E-mail: _____

Include your Check Payable to:
Mental Health News Education, Inc.
(or pay by credit card at www.mhnews.org)

cut out this coupon and mail it with your check to:

Mental Health News Education, Inc.
460 Cascade Drive, Effort, PA 18330

Phone: (570) 629-5960 E-mail: iraminot@mhnews.org

Advertise in Mental Health News

*** 25% Savings - Book 3 Get 1 Free!!**

- ☐ Business Card - 4 issues ($500)
- ☐ Eighth Page (1 issue $300 - 4 issues* $900)
- ☐ Quarter Page (1 issue $500 - 4 issues* $1,500)
- ☐ Half Page (1 issue $750 - 4 issues* $2,250)
- ☐ Full Page (1 issue $1,000 - 4 issues* $3,000)
- ☐ Inside Covers & Back Page (please call)
- ☐ Special Multi-page Supplements (please call)
- ☐ Honorary Sponsorship (please call)

Name & Title: _____

Address: _____

_____ Zip: _____

Phone: _____ E-mail: _____

Include your Check Payable to:
Mental Health News Education, Inc.
(or pay by credit card at www.mhnews.org)

cut out this coupon and mail it with your check to:

Mental Health News Education, Inc
460 Cascade Drive, Effort, PA 18330

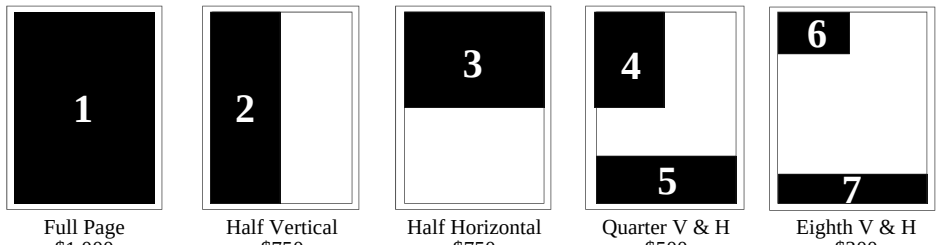
Phone: (570) 629-5960 E-mail: iraminot@mhnews.org

Promote Your Vital Programs and Services for the Mental Health Community
And Reach Our 160,000 Readers
Place Your Advertisement for the Year In Advance and Save 25%

Deadline Calendar and Ad Size Specifications

Deadline Dates

Spring Issue - January 23, 2013
Summer Issue - April 23, 2013
Fall Issue - July 23, 2013
Winter Issue - October 23, 2014



Full Page $1,000 | Half Vertical $750 | Half Horizontal $750 | Quarter V & H $500 | Eighth V & H $300

Ad Sizes - In Inches

	Width	Height
Full Page (1)	10.4	12.8
Half Vertical (2)	5.1	12.8
Half Horizontal (3)	10.4	6.4
Quarter Vertical (4)	5.1	6.4
Quarter Horizontal (5)	10.4	3.1
Eighth Vertical (6)	5.1	3.1
Eighth Horizontal (7)	10.4	1.5
Business Card (not shown)	5.1	1.5

MENTAL HEALTH NEWS

Recovery from mental illness is possible but it takes a community of support.

Mental Health News provides news, information, education, advocacy, and resources in the community that adhere to our strict evidence-based standards and is a vital link to that community of support.

Learn how Mental Health News can help provide your organization or community group with an affordable and trusted source of mental health education.

Call us today at (570) 629-5960 or visit our website at www.mhnews.org