

TRAUMA MATTERS

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TRAUMA: A VIEW FROM THE RESEARCH SIDE

I moved to Washington D.C. from Dallas, Texas to pursue a doctoral degree in Clinical Psychology. My deep passion for working with victims of violence attracted me to the research interviewer position for the Women's Trauma Collaboration Study and I have been working in this capacity for one year now. Prior to coming to Community Connections, I had no experience in research interviewing. Coming from a clinical background, I was somewhat uncomfortable with the limits of a standardized interview, especially since I was going to be conducting interviews that asked many questions regarding past traumatic experiences that were likely to elicit emotional reactions. What would it be like when a client became emotional and I had to continue to adhere to protocol rather than providing some type of counseling? How would women feel when they were asked to disclose intimate details of their lives by selecting the answer from a laminated card that best matched their experience? How would I keep participants engaged in an interview that consists predominantly of closed ended questions? Would women be honest with me, a perfect stranger about their histories of substance abuse, trauma, and mental illness? After one year as a research interviewer with Community Connections, I have found encouraging answers to all these questions. In doing so, I have learned a great deal about interpersonal interactions and the power of research interviews.

Perhaps the biggest lesson I have learned is that the very act of interviewing someone can communicate interest and concern for their life and well being. Many of the women I have interviewed have shared with me how they benefited from the interview. They often tell me how helpful the interviews are in helping them work through their problems. To them, selecting standardized answer choices from a laminated card is a positive experience because on the other side of the table is a

person who is interested in learning about them and understanding their challenges. I have also learned the power of nonverbal communication.

I have become skilled at using my face, body, and my tone of voice to express interest, concern, and empathy. As I expected, a number of clients do have emotional reactions during the interview, particularly when asked about their history of trauma and abuse. Surprisingly, however, I have found them to be easily comforted by an empathetic look, a peaceful silence or by my gentle gesture of handing them a box of tissues. I have found that if I enter each interview with a genuine interest in learning about the participant, that interest gets communicated and the experience can be rich and therapeutic.

I have been touched by the patience and honesty of the women I interview. The interviews I conduct take an average of two hours to complete and many of the questions are repetitive. For example, one participant proudly noted that the interview contains five different variations of the question "Have you been to jail?" Most women I interview think about each question and provide careful and thoughtful answers. I have been surprised to find how eager they are to give honest answers that represent their reality. For example, at times, participants ask me to go back and change their answers to certain questions because they feel they did not make the best answer selection. Rarely do I find a participant who gets upset with personal and somewhat intrusive questions.

My appreciation for research has grown immensely since joining the Community Connections Research team. As part of the Women and Violence Study, I have been privileged to hear stories of many women as well as their perceptions of the services they receive, and what has been helpful and hurtful to them in their recovery. Nothing motivates me more than knowing that through this research study we will be able to learn to better help women like these.

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Renata Cerqueira BS,
Community Connections, Washington, DC*

A RANDOMIZED TRIAL TESTING TARGET

In October 2000, the Connecticut Department of Mental Health and Addiction Services (DMHAS) received \$900,000 from the federal Center for Substance Abuse Treatment (CSAT) as part of its Co-occurring Disorders Initiative. Of the 12 sites receiving funding from this cooperative agreement, Connecticut was the only center focusing on co-occurring substance use and trauma disorders. The study is being conducted by Linda Frisman, Ph.D., Director of Research at DMHAS and Research Professor with the University of Connecticut Department of Psychology; and Julian Ford, Ph.D., Associate Professor in the Department of Psychiatry of the University of Connecticut School of Medicine. The study is a test of the Trauma Adaptive Recovery Group Education and Therapy for Addiction Recovery (TARGET-AR) model, a 9-week, gender-specific, skills-based groups. Developed by Dr. Ford, the TARGET model focuses on dealing with problems related to trauma disorders, rather than the traumatic experience.

The TARGET study was conducted in partnership with three substance abuse outpatient clinics: the Morris Foundation in Waterbury, and Rushford Center and the Connection in Middletown. To prepare to be TARGET group leaders, selected clinicians from Morris, Rushford, and Connection received an intensive 3-day training from Dr. Ford, and continued to receive monthly consultation from Dr. Ford and from Sharon Mallon, Ph.D., of the DMHAS Research Division. Groups were co-led by clinical psychology doctoral students who also tracked fidelity to the treatment model.

A total of 212 study participants were recruited, including 83 men and 129 women. To be eligible, participants had to be adults in outpatient substance abuse treatment, with a history of trauma, and meeting diagnostic criteria for at least one related psychiatric disorder: Post-Traumatic Stress Disorder (PTSD); Disorders of Extreme Stress, Not Otherwise Specified (DESNOS); Depression; or Dissociative Disorder. These diagnoses, along with a trauma history, were established through clinical interviews conducted prior to enrollment. Those who met criteria and provided informed consent were randomly assigned to receive TARGET in addition to substance abuse treatment (n = 140); or to receive usual treatment alone (n = 72). However, prior to study initiation, all clinicians in each of the centers received a 3-hour training in trauma sensitive approaches, so that the actual comparison was usual care, as enhanced with trauma sensitivity. Also, it should be noted that study participants in the comparison condition were invited to participate in TARGET groups after completing one year in the study. Recruitment for the study was completed in December 2002, and the study group will continue collecting follow-up data until each participant has completed interviews at 6 and 12 months from baseline.

Although outcome analyses cannot be conducted until this data collection is complete in January 2004, the study team has begun to consider information available from baseline data alone. Specifically, they are interested in the differences between male and female participants, because little has been reported in the literature about gender differences among trauma survivors.

Overall, about 58% of the study participants were women. Just under one-quarter (22.5%) were African American, and slightly over 10% were Latino. The study team was not able to include monolingual Spanish-speaking persons, because no groups were available in Spanish. (Outside the study, TARGET groups are now being offered in Spanish.) About half of the participants (54.9%) were high school graduates or had a General Equivalency Diploma, but only 17.9% were currently employed. Also, few (19.1%) were married at the time of study enrollment.

As shown in Table 1, women in the study were somewhat younger than the men. Other differences shown on this table are not statistically significant. However, a greater proportion of the women have housing, and have recently been in a residential program. Both men and women have considerable experience with substance abuse treatment: women average over six prior treatment episodes, and men average over seven. More of the men are in treatment for a primary alcohol problem.

Table 1. Gender Comparisons, Demographics and Substance Abuse

	Women	Men
Mean Age*	36.1	40.1
Living apartment or house	55.0%	39.1%
Residential program past 90 days	41%	25%
Past treatment episodes	6.3	7.2
Primary Substance Abused		
Alcohol	32.1%	48.8%
Crack or other Cocaine	22.9%	21.9%
Heroin	20.2%	15.6%
*Significant (p <.005)		

Differences in Trauma History. Several gender differences have emerged with respect to trauma history, as shown in Table 2. Males were younger at the time of their first traumatic event (age 8.7, compared to 12.0 years for females). Women were more likely to have experienced sexual abuse or rape and physical abuse other than child abuse. Also, women had more often been threatened with a weapon or otherwise felt fearful in a close relationship. Men, however, were more likely to have lived through a life-threatening injury or illness. Surprisingly, men were as likely as women to have been the victim of attempted sexual abuse, even though the women were more likely to be victims of completed sexual abuse.

Table 2. Gender Comparisons, Trauma History, Diagnosis, and Symptoms

	Women	Men
Age of first traumatic event****	12.0	8.7
Sexual abuse or rape (completed)****	85%	44%
Sexual abuse (attempted)	39%	26%
Parental child abuse	61%	68%
Threatened weapon, fearful in close relationship****	70%	35%
Emotional abuse in close relationship**	83%	68%
Life threatening injury/illness****	46%	65%
Diagnosis		
PTSD	83%	89%
DESNOS	38%	31%
Depression	59%	52%
Symptoms		
# Re-experiencing symptoms*	3.56	3.15
Somatization ***	77%	56%
Alterations in consciousness****	87%	65%
Total # types of trauma	9.6	9.0
Significant (*p<.1; **p<.05; ***p<.01; ****p<.0001)		

The differences in trauma history yield few gender differences with respect to diagnoses. Men and women are equally likely to meet criteria for PTSD, DESNOS, and Depression, and to have similar numbers of symptoms, frequency and intensity of symptoms, and levels of distress. However, women had slightly more symptoms related to re-experiencing their trauma, and to have problems with their physical health (somatization) and dissociation. Overall, the amount of trauma experienced by the study participants was very high, with an average of 9.6 different types of trauma for women, and 9.0 types for men. Although it is too early to present outcomes data for this study, preliminary results suggest that TARGET has a positive effect on psychiatric symptoms, and thoughts about oneself and the world. The investigators look forward to presenting the complete findings approximately one year from now. For more information, contact Linda Frisman @ 860-418-6788.

Childhood Sexual Abuse and Schizophrenia

A study reported in *Psychiatric Services* explored the association between sexual abuse in childhood and the severity of psychosocial deficits in adults with schizophrenia. Of 54 individuals in the study, 19 reported having been sexually abused as children, and 35 reported no history of abuse. The Quality of Life Scale, which assesses current interpersonal and work function, and the NEO personality inventory, which assesses personality dimensions relevant to social functioning, were administered to each of the 54 individuals who had been diagnosed as having schizophrenia. The results indicated that there were differences between the group who had a history of sexual trauma and the group that did not. The individuals with a history of abuse had poorer current role functioning and fewer of the basic psychological building blocks necessary for sustaining intimacy. They also demonstrated higher levels of neuroticism, which is a measure of vulnerability to emotional turmoil. The two groups did not differ in frequency of interpersonal contacts or level of extroversion.

“Childhood Sexual Trauma and Psychosocial Functioning in Adults with Schizophrenia”
Paul H. Lysaker, et al. *Psychiatric Services* 52:1485-1488, November 2001

**CULTURAL, BIOLOGICAL, & PSYCHOLOGICAL
FOUNDATIONS OF TRAUMA**

April 14, 21, & 28, 2003

Keller Auditorium, UConn Health Center, Farmington, CT

This 3-day training is offered by DMHAS and the Connecticut Women’s Consortium at no cost to participants and will address critically important issues in understanding the connections between the social and political factors of poverty and oppression, the risk and protective aspects of culture, and the long-term impact of individual and mass trauma. The objective of the training is to raise awareness and change the consciousness of providers in the behavioral health field and to share cutting-edge struggles and issues of trauma and culture.

- Day one will focus on the cumulative experiences of classism, racism, gender discrimination, and mass trauma on individual, family, and community functioning.
- On day two, the perspective will change to the role of the provider in intervening to counteract the multigenerational legacies of trauma and accessing the healing potential of culture.
- Day three will address the development of culturally-informed and trauma-sensitive services through the use of a case conference format. Participants will have the opportunity to formally present and discuss a case to our panel of four speakers.

For more information, contact Maria Ramos @ 203-498-4184 (XT 17)

Getting into Trauma Matters

- You can access an electronic version of the “Trauma Matters” Newsletter at www.traumamatters.org or www.womensconsortium.org
- Do you want to be placed on our mailing list or is there an event or topic you would like covered in this newsletter? Please

