

TRAUMA MATTERS

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CORE PRINCIPLES OF TRAUMA INFORMED CARE (PART 4)

This is a continuation of the series discussing each of the core principles (domains) of trauma informed care. The development of the domains are the work of Fallot & Harris (2006) with implementation ideas gathered from a variety of sources during the past few years, including survivors/consumers, direct care workers, written "lessons" learned, and researchers.

Domain #1d- Collaboration

Collaboration and choice (domain #1c) are closely related. However, without collaboration, choice loses its power. Maximizing choice generally means expanding the number and kinds of options available to consumers. Collaboration refers to shared decision-making about both the options to be offered and about how to implement consumers' plans. Responses to collaboration can range from the negative end of the continuum: unopened suggestion boxes or forgotten surveys or an attitude of "your best thinking got you here" to the positive end: styles of relating that value clients/consumers as full partners in achieving recovery goals. The provider's stance is no longer, "Here is what I can do to fix you." Rather, providers ask, "What can you and I do together to meet your goals for recovery?" When providers see that collaboration is part of the healing process from psychological trauma and a way to improve the effectiveness of treatment, they are able to ask: "How can services be modified to ensure that collaboration and power sharing are maximized?" (Fallot & Harris, 2006)

Some of the specific questions that have emerged in these discussions are the following:

- How do clients/consumers have a significant role in planning and evaluating the agency's services? Is there a Consumer Advisory Board? In reviewing implementation plans

from agencies that are moving toward a trauma-informed environment several common themes are emerging. One of these themes is identifying the need to strengthen collaboration. Ninety percent of the plans indicate the need to implement or strengthen an advisory board or to utilize surveys of former and current clients/consumers.

- Are clients/consumers involved in service and treatment planning? Are clients/consumer preferences given substantial weight? How easy is it for someone to change their mind? A group of clients/consumers recently told me (Eileen) that they find service planning meetings "stupid" and they "sign anything to get out of the intimidating room". When treatment planning is done with a primary counselor/therapist who is not collaborative, the treatment plan does not reflect "reality" and has "nothing to do with me".
- Do providers communicate respect for the client/consumer's life experiences and history, allowing the consumer to place them in context? For example, rather than simply "confronting" a consumer about substance abuse, the provider may collaboratively explore triggers for use, including connections between a history of violent victimization and the use of drugs or alcohol.
- Do agencies promote an atmosphere of doing "with" rather than doing "to" or "for"?

As stated in part 3 of this series, but worth repeating: behavioral health and medical services have come from a historical position of expert superiority. Collaboration takes time, energy and planning. However, in the long-term, collaboration saves time, conserves energy and makes our jobs easier, effective, and more fulfilling. Collaboration is another of the domains that challenge agencies and practitioners to view clients/consumers as experts in their own care.

Submitted by:
Eileen M. Russo, MA, LADC
Roger Fallot, PhD

THE PSYCHOLOGICAL TRAUMA AND STRESS OF WAR AND HOMECOMING FOR MILITARY PERSONNEL

Serving in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) and Their Families

In 2004, a study of returning OEF/OIF veterans estimated that one in six had post-traumatic stress disorder (PTSD) (Hoge et al., 2004), comparable to the prevalence of PTSD among Viet Nam war combat veterans twenty years after that war – and less than can be expected based on past studies showing that PTSD prevalence increases over time following combat deployment and when war shifts from liberation to containing civil conflict (Friedman, 2004). Many returning personnel with PTSD (60-77%) do not seek or receive help for PTSD (Hoge et al., 2004), although the Department of Veterans Affairs provides disability evaluations for all personnel who are identified as having potential psychological impairments upon return from OEF/OIF.

The nature of conflict both in Afghanistan and Iraq exposes military personnel to many forms of psychological trauma, including witnessing (both other military personnel and civilians') deaths or horrific injury due to car bombs, improvised explosive devices, mortar and sniper attacks. OEF and OIF military personnel also are exposed to conditions that increase the need for hypervigilance, such as great difficulty distinguishing friends from foes among indigenous civilians, police, and soldiers, extreme heat and cold, prolonged separation from home and family, and economic hardship.

Homecoming often is joyful, but can also be stressful for military personnel and their families. After having adjusted to high levels of chaos and threat in combat zones, neither the body nor the mind can easily re-calibrate to "ordinary" life. Post-traumatic stress symptoms such as troubling memories, reacting as if still in mortal danger, nightmares, feeling emotionally detached even from loved ones, and feeling on-edge and easily angered are an expectable result of this difficult shifting of gears from "survival mode" to "normal" living. When military personnel and their families understand that these post-traumatic reactions are a necessary adjustment and not a sign of illness, weakness, or failure – on the part of the soldier or of the family member – they are often able to seek help without feeling stigmatized and to learn ways to together "come home" from the war. Families experience many stressors on the "home front," including constant fear that their loved one will be killed (while seeing daily reports of mounting casualties), the burden of single parenting, loneliness due to the separation, and pressure to maintain the family's emotional and economic security with a key member missing. Thus, after the initial honeymoon period of first homecoming, the military person's post-traumatic stress and the family members' home front stress both deserve attention. Public education is essential to enlist the support of formal and informal resources such as friends, clergy, veterans' and community organizations, employers, and mental health professionals, in order to help military personnel and their families successfully return from the stress and dangers of war.

Submitted by:
Julian Ford, PhD
UConn Medical Health Center

FEATURED RESOURCE

The book, *War and the Soul* by Edward Tick, PhD is a heart wrenching journey into what it means to be a combat veteran. Parts of this book were a slow read for me, but those who study Jungian theories will feel differently. However, this is not a reason to skip this book. I found the author's description of the functions of the soul in each human the best I have read on this subject (Chapter 1). Later, Chapter 6 (*Inside PTSD: Identity and Soul Wound*) describes the trauma of war in plain language and from the point of view of those who have survived.

"Veterans know that, having been to hell and back, they are different. We expect them to put war behind them and join the ordinary flow of civilian life. But it is impossible for them to do so and wrong of us to request it. ...When the survivor cannot leave war's expectations, values and losses behind, it becomes the eternal present. This frozen war consciousness is the condition we call post-traumatic stress disorder." (p. 98-99)

Dr. Tick concludes with messages of hope and healing as he talks about his work with veterans, including reconciliation journeys and veterans retreats. Since publication of his book in 2005, Dr. Tick has established a website: www.soldiersheart.net. On this website you will find information on how to purchase the book, planned retreats and copies of the Soldier's Heart newsletter.

Submitted by:
Eileen M. Russo, MA, LADC

Connecticut's Military Support Program

In the context of an all-volunteer service, the military has relied heavily on our nation's Reserve Component during the Global War on Terrorism. At one point during 2005, National Guard members represented over 50% of our military forces serving in Afghanistan and Iraq. The burden we have placed on our Citizen Soldiers and their families has been, and continues to be, enormous. The large number of National Guard and Reserve personnel who have been activated and deployed to Iraq and Afghanistan raises significant complexity in the provision of behavioral health care. National Guard and Reserve troops are often dispersed within the civilian community and may live some distance from military treatment facilities and Veteran Administration (VA) medical centers, making outreach efforts and mental health services difficult to deliver. Additionally, these individuals and their families may not qualify for the same services as active duty personnel who receive comprehensive care through the military's direct care system. While those deployed in Operation Enduring Freedom (Afghanistan) and Operation Iraqi Freedom who have an honorable or general discharge are eligible for two years of health care through VA medical centers and clinics; there is no provision for therapy for their family members.

Connecticut's response to the reported psychological needs of deployed personnel and their family members is the new Department of Mental Health & Addiction Services' (DMHAS) Military Support Program (MSP). The program was established by the Connecticut General Assembly (Sec. 17a-453d) to address the mental health needs of National Guard and Reserve personnel and their family members affected by deployment to combat areas. It was officially implemented by DMHAS in March 2007. The program is unique in that Connecticut is the first state in the nation to provide mental health counseling services to National Guard/Reserve personnel **and** their family members. Maintaining the psychological health, enhancing the resilience, and ensuring the recovery of citizen soldiers and their family members following their experience in war is a newly assigned responsibility that DMHAS is proud to fulfill.

The program provides free, confidential, timely and flexible outpatient counseling services to National Guard and Reserve personnel and their families in community settings throughout the state. The central feature of the program is a statewide panel of over 200 licensed clinicians who stand ready to provide confidential counseling services that include marriage and family counseling, as well as counseling for stress related to deployment, combat and homecoming. DMHAS contracted with Advanced Behavioral Health, Inc. (ABH), a Middletown-based administrative services organization, for the purpose of recruiting, training, credentialing and managing the statewide panel.

National Guard/Reserve personnel and their family members seeking referral to counseling services are encouraged to access the program through a **24/7 toll-free call center** that is managed by ABH. When a soldier or their family member calls, they are provided the names and contact numbers of at least three Clinicians in their area. MSP staff persons support the process by providing outreach; information, referral and advocacy and community case management services. **The toll free number is: 1-866-251-2913.**

The following reports provide valuable information regarding the behavioral health concerns of returning service personnel and their families:

- The Final Report of the Department of Defense Task Force on Mental Health, released in June 2007 (www.ha.osd.mil/dhb/mhtf/mhtf-report-final.pdf)
- The Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report, issued in February 2007 by the American Psychological Association (www.apa.org/releases/MilitaryDeploymentTaskForceReport.pdf).
- Report of the President's Commission on Care of Wounded Warriors (www.pccww.gov)

Submitted by:
Jim Tackett, Director
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Dept. of Mental Health & Addiction Services

Getting into Trauma Matters

- You can access an electronic version of the "Trauma Matters" Newsletter at www.traumamatters.org; www.dmhas.state.ct.us; 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 call "Trauma Matters" editor Carol Huckaby at 203.498.4184, x25 or e-mail her at chuckaby@womensconsortium.org.


SAFETY TIPS FOR VETERANS AND FAMILY MEMBERS (DEALING WITH HOMECOMING)

- Build a support network with family members, close friends, neighbors, your religious/spiritual group, community, doctors, and other health professionals.
- Take time to listen and talk with loved ones. Use effective communication starting with “I,” such as “I think” or “I feel.” “You” statements can sound accusing.
- Put your feelings into words and help your family members put feelings into words. Ask, “Are you feeling angry? Sad? Worried?”
- Be a good listener. Don’t give advice unless you are asked. Ask how you can help.
- Be positive. Remember and be supportive of good things your family has done. Blame and negative talk won’t help the situation.
- Learn as much as you can about PTSD. Knowing how PTSD affects people may help you understand what your family member is going through. The more you know, the better you and your family can handle PTSD.
- Understand that anger is a normal reaction to trauma, but it can be frightening and hurt relationships. If anger leads to violent behavior or abuse, it is DANGEROUS. Go to a safe place, call for help right away, and make sure your children are in a safe place.
- Take a time-out when you or someone is angry. While taking a time-out, don’t focus on how angry you feel. Instead, think calmly about how you will talk things over and solve the problem.
- Don’t feel guilty or feel that you have to solve all the problems.
- Take care of your physical and mental health. Eat healthy foods that will give you more energy to carry you through the day. Get regular exercise that is a healthy way to deal with stress.
- Plan family activities together, like having a dinner, going to a movie, taking a walk, going for a bike ride, or doing some other physical activity. Exercise is important for health and helps clear your mind.
- Take time to be by yourself. Find a quiet place to gather your thoughts and “recharge.”

(Reference: National Center for Posttraumatic Stress of Department of Veterans Affairs. Retrieved from www.ncptsd.va.gov on 8/27/2007)

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