BC Partners for Mental Health and Addictions Information

# Visions

BC's Mental Health and Addictions Journal

Vol. 3 No. 3 | Winter 2007

# trauma & victimization

## background



## experiences & perspectives



## alternatives & approaches



### bc partners

Seven provincial mental health and addictions agencies are working together in a collective known as the BC Partners for Mental Health and Addictions Information. We represent the Anxiety Disorders Association of BC, British Columbia Schizophrenia Society, Canadian Mental Health Association's BC Division, Centre for Addictions Research of BC, FORCE Society for Kids' Mental Health Care, Jessie's Hope Society and the Mood Disorders Association of BC. Our reason for coming together is that we recognize that a number of groups need to have access to accurate, standard and timely information on mental health, mental disorders and addictions, including information on evidence-based services, supports and self-management.

### visions

Published quarterly, *Visions* is a nationally award-winning journal which provides a forum for the voices of people living with a mental disorder or substance use problem, their family and friends, and service providers in BC. Visions is written by and for people who have used mental health or addictions services (also known as consumers), family and friends, mental health and addictions service providers, providers from various other sectors, and leaders and decision-makers in the field. It creates a place where many perspectives on mental health and addictions issues can be heard. To that end, we invite readers' comments and concerns regarding the articles and opinions expressed in this journal.


The BC Partners are grateful to BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority, for providing financial support for the production of Visions

## regional programs



## web-only articles

available at www.heretohelp.bc.ca/publications/visions



There are two things I associate with trauma. Boxing Day 2005 watching a huge wall of water surge over people and buildings without much warning, I wondered how the people actually living through that tsunami would ever be able to look at the sea again without fear. I also recall watching a documentary with Lieutenant-General Romeo Dallaire returning to Rwanda. His moving recollection of his time there and his struggles once he returned home deeply affected me. These are traumas on a population and distant level.

There is also trauma on an individual scale: the recent illness of my mother and close friends, the death of a couple friends of my son's. All these things begin to add up. For some people, there are more horrible things that affect them so deeply that it takes years to overcome. I guess what I am trying to say here is that trauma affects everyone at one point or another. And as one article in this issue points out, it even affects those who come in to help with trauma —in a vicarious way. The question becomes then why do some people seem to be able to navigate traumatic experiences with not too many problems while others become very affected?

The articles in this issue look at the variety of theories, programs, services and experiences that come to represent our work on trauma and victimization today. As always, there are issues and theories that we have left out, mostly because we are unable to include everything in one issue. But one thing is for sure, there is some serious food for thought and action here.

As this is my penultimate issue as policy/content editor, I just want to take this chance to express my gratitude to the amazing group who works so hard to put together each issue of *Visions*. I knew coming in that this was a magazine that presented difficult topics in sensitive and thoughtful ways….and this is because there are so many people committed to each and every issue, and because there is a huge variety of dedicated people working in mental health and addictions in this province. But my deepest gratitude goes out to those people who write about their lived experience. This is an act of great courage but mostly is seems it is an act of faith, faith that in telling their story things can and do change. All the rest of us have to do is listen and learn.

*Christina Martens*


*Christina is Executive Director of the Canadian Mental Health Association's Mid-Island and Cowichan Valley Branches. She has an MEd in Community Rehabilitation and Disability Studies and is working towards her doctorate in Policy and Practice in the Faculty of Human and Social Development at the University of Victoria*


## subscriptions and advertising

If you have personal experience with mental health or substance use problems as a consumer of services or as a family member, or provide mental health or addictions services in the public or voluntary sector, and you reside in BC, you are entitled to receive *Visions* free of charge (one free copy per agency address). You may also be receiving *Visions* as a member of one of the seven provincial agencies that make up the BC Partners. For all others, subscriptions are $25 (Cdn.) for four issues. Back issues are $7 for hard copies, or are freely available from our website. Contact us to inquire about receiving, writing for, or advertising in the journal. Advertising rates and deadlines are also online. See www.heretohelp.bc.ca/publications/visions.

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# Psychological Trauma: A Common Problem

## Knowledge, myths and unanswered questions

William J. Koch

*Dr. Koch holds adjunct appointments at the University of British Columbia and at Simon Fraser University. He co-authored* Psychological Injuries: Forensic Assessment, Treatment, and Law, *published in 2005 by Oxford University Press. Dr. Koch practices and publishes extensively with respect to the consequences of trauma. Visit his website at www.drwilliamkoch.com*

This special issue of *Visions* on trauma and victimization discusses trauma and its results in a variety of contexts (e.g., sexual abuse, car accidents, the workplace, the military and emergency workers). These articles, however, barely scratch the surface of our current knowledge of trauma and its relationship to people's mental and physical health.

Authors have described the consequences of trauma for centuries. It is now common knowledge that people exposed to assaults, military combat, natural disasters and car accidents are at risk for lingering emotional distress. However, the characteristics of trauma that lead to distress and the relative contribution of the trauma versus people's pre-existing personalities are still matters of debate among academics.

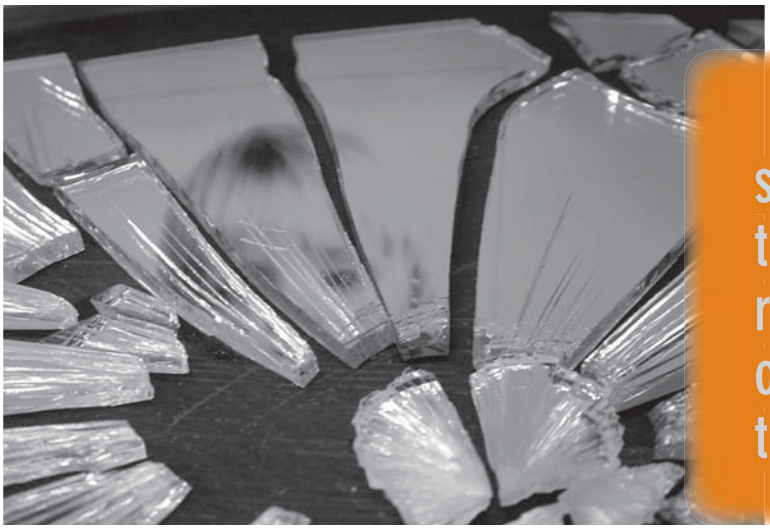
Early research focused on the effects of large-scale military trauma (e.g., American Civil War, Vietnam War) or of large-scale disasters (e.g., floods, fires). Early diagnostic systems created a myth that severe psychological distress could result only from extraordinary traumas that are not part of most people's lives. This myth has largely been discredited by modern research.[1]

Similarly, early writings suggested that everyone exposed to such traumas would develop mental health problems. Extensive research has shown that many people are initially very distressed following trauma, but that only a small number of people develop long-standing mental health problems. For example, childhood sexual abuse is widely considered the most powerful traumatic stressor commonly studied. It is clear, however, that for the vast majority of childhood sexual abuse survivors, the event itself is associated with little psychological distress in adulthood.[2] In short, the psychological distress associated with traumatic stress passes relatively quickly for most people. This does not trivialize the distress suffered by chronic sufferers, but illustrates that some individuals respond to trauma with greater resiliency than do others. We are still learning which factors provide resiliency or vulnerability following trauma. Such research is especially important for developing more effective treatments.

What makes a trauma traumatic? There is substantial debate about the definition of trauma, with some scientists arguing for a limited spectrum of life-threatening experiences and others arguing that many different life events (e.g., sexual harassment, marital infidelity) are potentially traumatic. Any event that is able to induce an immediate state of severe fear, helplessness or horror can be a traumatic stressor. Types of trauma more likely to result in post-traumatic stress disorder (PTSD) include physical assault, car accidents and life-threatening illnesses (e.g., cancer).

The best predictors of PTSD are the person's emotional responses at the time of the trauma (e.g., extreme fear, panic, shock). The next best predictor is previous history of anxiety or depression. The third predictor is stress following the trauma (e.g., financial problems, low social support, chronic pain). Objective physical characteristics of the trauma (e.g., damage to vehicles) typically finish a distant fourth in predicting who develops PTSD.

PTSD is not the only mental health problem that



**some individuals respond to trauma with greater resiliency than do others—we are still trying to understand why**

can follow trauma. Fifty per cent of individuals suffering from PTSD also suffer from depression, and as many as one-third of PTSD sufferers also suffer from another anxiety disorder (e.g., panic disorder, generalized anxiety disorder). Alcohol and drug abuse also occur frequently in PTSD sufferers. Finally, recent research shows that trauma, PTSD and depression change personal health perceptions, physical health and use of medical care. That is to say, psychological trauma can make us physically sick.

Trauma not only causes many different mental health problems, but it can also be a consequence of such problems. For example, alcohol intoxication is perhaps the best predictor of being a victim of sexual assault. This has obvious implications for preventing trauma, leading to research on rape prevention.

We sometimes learn that what we commonly do in clinical practice has little benefit. Sympathy for trauma survivors and misguided good intentions has sometimes led to ill-considered treatments. Although there are effective treatments for both acutely and chronically distressed trauma survivors (see page 23), other interventions, such as single-session debriefing given shortly after the trauma incident, have failed to demonstrate any benefit to patients (see page 7). I usually urge clinicians to focus less on the specific type of trauma and more on the immediate emotional experience of the trauma survivor.

In summary, trauma is a very large area of research and clinical practice. Over the past 25 years we have learned a great deal about the consequences of trauma, about better and worse methods of coping with trauma and about effective treatments. However, much remains to be learned about vulnerability factors (see page 6), the prevention of trauma, early intervention for distressed trauma survivors, and effective treatments for chronic PTSD.

### footnotes

1. Norris, F.H. (1992). Epidemiology of trauma: Frequency and impact of different potentially traumatic events on different demographic groups. *Journal of Consulting and Clinical Psychology*, 60, 409-418.

2. Rind, B., Tromovitch, P. & Bauserman, R. (1998). Meta-analytic examination of assumed properties of child sexual abuse using college samples. *Psychological Bulletin*, 124(1), 22-53.

## we want your feedback!

*If you have a comment about something you've read in* Visions *that you'd like to share, please e-mail us at bcpartners@heretohelp.bc.ca with 'Visions Letter' in the subject line. Or fax us at 604-688-3236. Or mail your letter to the address on page 3. Letters should be no longer than 300 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive.*

I'd like to say how consistently impressed I am with *Visions* magazine. It is truly an outstanding publication. So much so that we've received permission to reprint two articles from the First Responders issue for our newsletter called *HIV/AIDS Prevention Resources for Educators: Reaching Students with Special Learning Needs*. We cover much more than HIV prevention—including different types of disabilities and the effect on learning, innovative programs for youth with disabilities and issues such as self-esteem, decision making, substance use, bullying etc. I think the Visions articles we've chosen provide great information for our readers. Thanks.

*—Shelley Hourston | Director, Wellness & Disability Program/AIDS & Disability Action Program/Health Literacy Network | BC Coalition of People with Disabilities*

Congratulation on such a fine fall 2006 issue of *Visions*. The theme "First responders for young people" is timely and the range of content and mix of contributors is admirable. I was pleased with the article by Annie Smith of the McCreary Centre Society and hope that it signals the beginning of greater interest by your partners in the rich data base and excellent reports on BC youth that the Society has generated during the past decade. For your readers' information, the issues of youth mental health (suicide awareness) and substance misuse (by early adolescents) are among the top priorities for our Foundation over the coming year. For more info on the McCreary Youth Foundation, visit www.myfoundation.ca.

*—Roger S Tonkin | Chair, McCreary Youth Foundation, Vancouver*

# Responding to Frightening Life Events

**Marilyn Laura Bowman, PhD**

*Dr. Bowman is a Professor Emerita at Simon Fraser University. Her research and clinical interests have focused on neuropsychological effects of brain trauma, and psychological effects of diverse traumas. She retired last year from SFU's Psychology department and a consulting practice in clinical neuropsychology*

When an event threatens our safety or that of our loved ones, our inner psychological resources are called upon as we try to cope. Contrary to popular thinking, there is no one "best" way to cope, and people don't all go through a set series of "stages" of coping. The reality of responding to stressful events is more complex than that.

Different individuals will respond differently to any given situation. Some people will respond with strong emotional changes that may include anxiety, fear, anger or depression. Others may experience little change in their emotional condition.

How individual people respond tends to be typical of the way each has faced other challenging or dangerous events in the past. One factor in how we respond is a lifetime of learning how to think about life's challenges and learning how to regulate our emotions. Another factor that affects an individual's response is his or her typical "background" emotional style or temperament, which has a significant genetic component—some individuals are more easily upset than others.

It is important to recognize that these individual variations are authentic and naturally occurring. An absence of vivid emotional symptoms should not be regarded as some sort of abnormal condition that needs intervention.

Most people who experience even very frightening and dangerous events do not develop mental disorders and do not seek treatment from mental health professionals. Instead, they work through their fear, relief, anger or other turbulent emotions, using habits they have developed throughout their lives.

Some individuals may talk about the event—with family members, a religious leader, a friend or a counsellor on a public "crisis line." Others may not wish to talk, preferring to think about their experience and put it into a longer perspective of how they or others have handled tough situations in the past.

**People don't all go through a set series of "stages" of coping. The reality of stressful events is more complex than that**

Some may seek comfort in distracting activities that have given them pleasure in the past, such as running, music, reading or travel. Yet others may conclude that their own best response is a kind of deliberate suppression. For some, this suppression may indeed be best, because we know that "avoidance" can be an effective strategy after an event with consequences that cannot be changed, such as sudden bereavement.

Keeping these individual differences in mind, there are, however, some responses after a frightening event that may represent a mental disorder. When a person's emotional turmoil is so great that it interferes with normal activities, formal treatment may be required. In the mental health professions we differentiate between two main stress-related mental disorders: "acute stress" disorder and "post-traumatic stress" disorder (PTSD).

Acute stress disorder consists of strongly increased emotions of anxiety and fear that are so severe they impair functioning in everyday life for a time, but resolve within four weeks after the event.

PTSD is an event-attributed anxiety disorder that lasts more than one month after exposure to a dangerous event. It includes powerful symptoms of intrusive memories or dreams of the event, episodes of increased arousal, and efforts to avoid stimuli related to the trauma. If a person has these symptoms so severely that he or she is highly distressed, or is unable to function adequately in normal life tasks, then the disorder may be diagnosed.

The percentage of people who develop a turbulent and persistent emotional response to a dangerous event is about 15%, with some variations in different groups.

People show amazing resilience through experiences of war, rape, assault and terrible accidents, using their own coping styles. Humans are social animals. Most of us find comfort in our family and friends once we are returned to a situation of safety—and, we can help others by quiet offers of support. In daily life we help each other through fearful situations by recognizing and respecting the different coping tactics that we and others use, and by not imposing any rigid model of 'how people are supposed to react.'

Whether our role is that of a family member or a professional, we should be sensitive to individual needs and styles, so that recovery of emotional well-being can arise naturally out of the person's own unique being.

**related resource**

Bowman, M. (1997). *Individual differences in posttraumatic response: Problems with the adversity–distress connection*. Mahwah, NJ: Lawrence Erlbaum.

# Critical Incident Stress Debriefing

## Concepts and Controversy

Katelin Bowes, Jill Fikowski and Melanie O'Neill, PhD

*Katelin is a fourth-year undergraduate student at Malaspina University-College, doing a double major in psychology and sociology. She plans to pursue a master's degree in speech pathology*

*Jill is a third-year undergrad at Malaspina. Currently a research assistant, she plans to do graduate work in clinical psychology, specializing in substance use and co-occurring disorders*

*Melanie is a Registered Psychologist and Professor at Malaspina, with clinical and research interest in post-traumatic stress disorder and obsessive-compulsive disorder*

People involved with, or exposed to, modern-day traumas can experience a range of emotional responses. Concern for victims of workplace and disaster-related trauma has led to increased popularity of early intervention and prevention strategies.

Critical incident stress debriefing (CISD) is one such strategy. CISD was originally developed by Dr. Jeffrey Mitchell to ease the acute stress responses of emergency workers.[1] A critical incident is any event faced by emergency service personnel that may cause strong emotional reactions that could interfere with their ability to function.[1] CISD hopes that immediate intervention following a traumatic event will eliminate or at least reduce delayed stress reactions.[1]

CISD is an intervention conducted by trained mental health professionals, in either group or individual format. CISD encourages traumatized individuals to share their thoughts and feelings about the critical incident, with the goal of making sense of the trauma.[2] Aside from the reassurance and support provided by the health care professional, resources and information regarding practical coping skills are also offered.[1]

Debriefing typically occurs two to three days following the traumatic event and can last three to five hours. Debriefing responses are now recommended as standard practice in many schools, workplaces and government organizations. For example, people witnessing or experiencing workplace- or school-based violence will often receive a debriefing intervention.

Controversy between debriefing and more clinically established therapies, such as cognitive-behavioural therapy, has been widely debated. Because it is difficult to demonstrate the effectiveness of CISD, the debate is likely to be ongoing.[3]

There is limited scientific evidence for the effectiveness of CISD. The untested thinking behind CISD is that early intervention for trauma may reduce more chronic psychological disorders.[4] While some findings support the use of CISD after a traumatic event and suggest it may be an effective tool of crisis intervention,[5] there is little direct evidence supporting its use to reduce or prevent future psychological symptoms.

However, there is evidence from studies that show individuals receiving CISD actually fared worse than those receiving no intervention.[6-7] What might account for these findings? One criticism of CISD is that it may prevent the "natural emotional processing" that follows a traumatic event.[8] CISD may also unintentionally lead trauma survivors to rely heavily on health professionals and, consequently, bypass the support of family and friends.[8] The fact is, many trauma survivors, despite the initial range of stress reactions, have their symptoms completely resolved within three months of the event, without any intervention at all.[9]

At present, personal testimonies are largely promoting the use and popularity of CISD.[10-11] In order to support its continued use, researchers must scientifically examine the effectiveness of CISD. They need to use adequate control groups (a comparison group of participants who do not receive the treatment being studied, often referred to as a placebo group or "sugar pill"). They need to follow-up and to look at the impact of CISD with different groups of traumatized people. Objectives for the use of CISD must also be re-examined,[10] to ensure that the long-term psychological and emotional recovery of the traumatized individual is the first priority.

CISD hopes that immediate intervention following a traumatic event will eliminate or at least reduce delayed stress reactions.

**footnotes**

visit www.heretohelp.bc.ca/publications/visions for Katelin, Jill and Melanie's complete footnotes or contact us by phone, fax or e-mail (see page 3).

# Victimization of People with Mental Illness

## Barriers to Reporting Crime

Liz McBratney

*Liz is a Court Services Supervisor and Advocate for the Motivation, Power and Achievement Society*

Working in the criminal court system has provided me with a great deal of experience assisting mental health consumers who are charged with criminal offences. I have also had many clients with mental illness who have suffered violence and discrimination at the hands of others.

People with mental illness frequently become vulnerable and easy targets of physical and mental abuses. This is particularly evident on the streets in Vancouver's Downtown Eastside. Many of these incidents don't get reported for a variety of reasons. A multitude of barriers come in to play, including discrimination, accessibility, fear of retaliation and the potentially intimidating court process.

### Discrimination

Stigma and discrimination are common barriers to reporting crime. Many victims with mental disorders fear they are perceived as not being credible because they suffer from delusions. They fear this is thought to impair their ability to recount events accurately.

Victims often suffer from shock, confusion, anger, humiliation and guilt, which can be intensified by a mental health condition. An interviewer may feel that a victim who is experiencing these symptoms is exaggerating details. Filtering what is fact and what is fiction is difficult, and the court has to ensure that witnesses are reliable.

It is my experience, in working with individuals in the courts who have past experience with abuse and violence, that they tend not to trust that the system will work in their favour. As a result, these victims are less likely to rely on the court system to fight their battles.

### Accessing support

Once a crime has been reported, it can take a significant amount of time and energy for the victim to follow through with all the follow-up requirements. Required practical tasks, such as filling in victim impact statement forms and providing medical information, also create barriers to accessing support in the criminal justice system.

Forms require an individual to have an address or contact number for follow-up, as well as a certain level of literacy. Also, these documents can be invasive and may require information and documentation from a physician.

Medical examinations can be included as part evidence for charge approval. But many mental health consumers don't want to seek medical attention, because they've had negative experiences involving hospital certifications or clinical care.

There is little support available to help people maintain mental health and self-care throughout the court process. More often, they need to access community mental health care through their physician or mental health team.

In my capacity as a mental health court worker with the Motivation, Power and Achievement Society (MPA), I have assisted people who have been victims by accompanying them to court or by helping them file documents, as per a judge's requests. This role ought to be performed by a government agency associated with court, or by a nonprofit service contracted to provide victims services. However, funding to victim-related resources has been cut in recent years.

### Fear of retaliation

A common barrier for victimized individuals when reporting offences is the fear of retaliation. Offenders may deliberately target people with mental illness because they see them as vulnerable and less likely to go to the police.

If street drugs play a part in the situation, the likelihood of someone reporting violations is further decreased. The individual may not want to disclose the fact that they have addiction issues. As well, they don't want to be subject to further harmful violations.

### Daunting court process

The court process itself is intimidating and anxiety producing. Anxiety and fear is further complicated by the fact that the person who has been victimized must once again see the accused in the law court. Also, the mentally ill person must deal with sheriffs and police in uniform, which can be difficult for those with negative past histories with authority, or delusions or paranoia related to authority systems.

## people with mental illness—victimized more

People with mental illness are more likely to be victimized than the general population—on average 11.8 times more often for violent crimes:

**Violent crimes**

- Rape and attempted rape: 22.5x more
- Sexual assault: 15x more
- Aggravated assault (attack for the purpose of inflicting severe bodily injury): 13.1x more
- Robbery with injury: 7.3x more

**Other crimes**

- Theft of property from a person: 140.4x more
- Household burglary: 4.9x more
- Theft of property from a place: 3.6x more
- Motor vehicle theft: 2.5x more

**source**

Teplin, L.A., McClelland, G.M., Abram, K.M. et al. (2005). Crime victimization in adults with severe mental illness: Comparison with the National Crime Victimization Survey. *Archives of General Psychiatry, 62*(8), 911-921.

As an advocate, I have also witnessed homeless people attempting to come into the building, but having nowhere to put their worldly possessions while attending court. This situation reduces the accessibility of the court process for these individuals.

It is important to recognize that all individuals, including those with mental illness, should be treated with respect and compassion while they cope with situations of violation. They should know that they are not alone.

Resources for assistance should be identified and made available to the victim. These may include women's groups, in the case of spousal abuse; mental health teams, for counselling and treatment; the Native Courtworker and Counselling Association, to assist Aboriginal people; and the provincial government Victim Safety Unit, which attempts to contact victims when offenders will be released in the community. At MPA, we will assist, however we can, by providing additional referrals to appropriate community services.

## responding to someone with a mental illness who has been victimized

**Remember that:**

- Being a victim of, or witness to, a crime is often traumatic and may trigger symptoms of mental illness
- Victims with mental illness might not disclose their condition. Therefore, some signs to watch for:
  - accelerated speech or unintelligible conversation
  - delusions, hallucinations, paranoia
  - depression
  - inappropriate emotional responses
  - memory loss
  - unfounded anxiety, panic or fright
- Approach from the front and maintain eye contact
- Introduce yourself and your role
- Remove victims from noisy environments (like crowds)
- Include victims in all conversations
- Explain your actions before proceeding
- Be calm, reassuring, patient and honest
- Contact someone in their support network
- Find out what they need to feel safer
- Keep interviews one-on-one, simple and brief
- Remember that despite paranoia or delusions, a person with serious mental illness may still be able to provide accurate details of the crime

**source**

Office for Victims of Crime. (2000). *Victim empowerment: Bridging the systems—Mental health and victim service providers (student material)*. Washington, DC: author. www.ojp.usdoj.gov/ovc/publications/infores/student/student.pdf.

Office for Victims of Crime. (2002). *First response to victims of crime who have a disability*. Washington, DC: author. www.ovc.gov/publications/infores/firstrep/2002/NCJ195500.pdf.


WARNING: This article contains graphic and disturbing content, intended for professions who have never heard of residential schools. It is here for archival purposes only. If you are Indigenous or a survivor, this may be traumatizing to read

# Indian Residential Schools
## The Aftermath

**Charles Brasfield, MD, PhD, FRCPC**

*Charles is doubly qualified as a psychiatrist and clinical psychologist. He is the Director of the North Shore Stress and Anxiety Clinic, was a Clinical Associate Professor in Psychiatry at UBC, and has been on staff at Lions Gate Hospital. Charles has long been active in Aboriginal mental health*

The last Indian residential school (IRS) closed in 1984. That ended a period of time in which the government of Canada had attempted to eliminate Aboriginal cultures, languages and social structures. The attempt failed.

I am a medical doctor who has been especially interested in Aboriginal mental health. Over the last two decades, I have treated many survivors of residential schools. It became clear to me that their lives had been dramatically changed by their attendance at an IRS. Other doctors who also treated many of those survivors labelled them as alcoholic, criminal or drug addicted. Often, those other doctors had not asked about attendance at residential school.

### Inherent psychological abuse

I noticed that many people's IRS experiences were similar. The pattern of experience begins with a child being forced to attend an IRS away from their home community. Upon arrival, he or she is separated from opposite sex siblings, punished for speaking in a native language and, in many of the schools, required to attend religious services foreign to them. In my view, this all constitutes psychological abuse.

### Sexual abuse

Many children attending an IRS were subjected to sexual abuse. For the most part, this consisted of anal rape of boys and vaginal rape of girls, although there was also some coerced oral sex. Most of the perpetrators were male members of the staff of the IRS. But it also happened that older students would sexually assault younger students. Most strikingly, these assaults occurred not once or twice, but for some children, continued every few days or weeks and over a period of years. One survivor reported to me an estimated 3,000 separate episodes of anal rape.

WARNING: This article contains graphic and disturbing content, intended for professions who have never heard of residential schools. It is here for archival purposes only. If you are Indigenous or a survivor, this may be traumatizing to read

While most of the perpetrators were male homosexual pedophiles, many young girls were also assaulted by male heterosexual pedophiles. In some cases, the continued sexual assaults lasted into adolescence and resulted in pregnancy. Some of the pregnant girls were sent home and some were simply discharged from the school in disgrace. With lesser frequency, I have also heard reports of female heterosexual and homosexual pedophiles who instructed children in techniques of masturbation (manual genital stimulation of self or another) and oral sex. Usually, the children selected for such instruction were preadolescent and not themselves sexually active. Usually, the children were very distressed by their experiences.

### Physical abuse

Much of the discipline of the residential schools was physical. That is, children were struck, beaten or otherwise physically punished for misbehaving. A typical punishment story is of being beaten with razor straps, rulers and yardsticks. Several people who attended one particular school told me of a female supervisor who had a special stick for inserting vaginally into little girls. Some people had significant scarring, damaged eyes and dental damage.

The classic story, which has been repeated to me many times, is of a young girl punished for speaking her own language. She was forced to kneel on broken glass in front of a cross, with her arms spread and with a needle propped under her tongue. No one has told me that they were that very little girl, but many people have told me the story.

### The aftermath

In their late teens, the IRS children were sent home from the residential schools. In most cases, they had had no training in parenting, minimal training in any employable skill and no support for their disturbed psychological functioning.

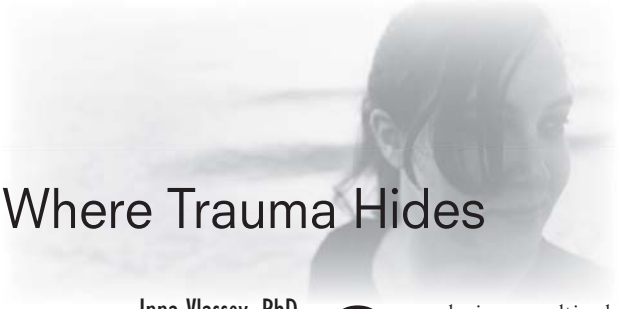
They had, however, been sexualized. They married and had their own children. Not surprisingly, they had difficulty parenting those children. They tended to parent as they had been parented in the IRS. That is, they punished their own children physically for misbehaving, and in many cases, treated them as sexual objects.

Unlike the IRS staff, this new generation of parents was genuinely fond of their children. It upset them to see their children upset, and they often consoled themselves with alcohol. So did their children. Physical violence and assault became commonplace.

This whole pattern was repeated for generations.

Today, most women on reserves have been sexually assaulted. Most people of both sexes have been physically assaulted. And nobody talks about it.

Only just now is the damage of the IRS system being recognized. Only just now are significant numbers of individuals beginning to talk about their traumatic experiences. Only now is some healing evident.



# Where Trauma Hides

**Inna Vlassev, PhD**

*Inna is a Psychologist in Vancouver who specializes in trauma and collaborates with the Cross Cultural Clinic located at Vancouver General Hospital*

Canada is a multicultural nation. Our neighbours, colleagues, spouses and parents have diverse ethnic and racial backgrounds. In the last decade the psychiatric literature has been full of research and scholarly work devoted to the significance of transcultural issues.[1]

Health care practitioners must be increasingly sensitive to cross-cultural concerns. This article explores the challenges presented by the crossing point of trauma and culture.

### The competent cultural assessment

Consider the following clinical scenario. A Bosnian woman in her young forties, previously a science teacher in her home country, has insomnia, low self-esteem, anxiety, feelings of guilt and marital stress. She uses alcohol to keep her anxiety under control. She arrived in Canada 13 years ago with her husband and small child, when ethnic war was ravaging the former Yugoslavia. The family was sponsored by a relative in Canada. The couple left reluctantly, mostly for the sake of their child. The family appears to have integrated into the new culture: both adults have professional jobs and a small number of friends, and their teenager is function-

**footnotes**

1. de Silva, P. (2006). *The tsunami and its aftermath in Sri Lanka: Explorations of a Buddhist perspective.* International Review of Psychiatry, 18(3), 281-287.

2. deVries, M.W. (1996). Trauma in cultural perspective. In B.A. van der Kolk, A.C. McFarlane & L. Weisaeth (Eds.). *Traumatic stress: The effects of overwhelming experience on mind, body and society* (pp. 398-416). New York: Guilford Press.

3. Herman, J. (1992). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror.* New York: BasicBooks.

ing relatively well at school.

As a capable clinician, you have completed a decent assessment of mental status. You have been mindful that this woman has had a life history in a different social context. You have explored with her the meaning of her physical and psychological complaints from the point of view of her native culture. The client expresses herself well in English, but, nevertheless, you check in with her for misunderstandings.

You have taken the time to evaluate how the uprooting affected her, what it is like to cope with daily stress away from the protective powers of one's culture.[2] The client readily talks about her sadness that she has no immediate family. She misses drinking the infamous black coffee with her parents and the intense heart-to-heart conversations with friends, to name just a few of the customs she took for granted.

Indeed, you have done an impressive amount of reading on the history and complexity of the ethnic structure in the Balkans. You have consulted with colleagues on their experience with refugees and immigrants from that region.

It is important, in this case, to screen for post-traumatic stress disorder (PTSD)—a condition that may develop after the experience of a life-threatening event. PTSD involves a response of intense fear or horror, helplessness, reliving the event through persistent memories, dreams or intrusive thoughts, and emotional numbing or extreme irritability, among other symptoms. Your findings on that are negative. Furthermore, your client's immediate family and relatives have not been involved directly in the war, and no one has been harmed. You have inquired whether faith plays a role in the client's life, as this is a way of evaluating strengths and coping skills.

The plan is to offer treatment for depression related to grief from losing her native land and couples work to assess the severity of marital conflict.

Generally, you relate with ease to this woman—she is well-spoken and impassioned when presenting her issues. Yet, as treatment begins, you find yourself feeling frustrated.

It is difficult to keep the focus in the sessions—the client brings up seemingly unrelated issues and talks in circles.

She has trouble speaking when she tries to revisit some experiences from the final days with her students in Bosnia. She avoids eye contact; her narrative becomes confusing—it's hard to keep the chronology of events clear. She refers to atrocities she didn't witness but knows her students and friends suffered. She presents them with such blandness and lack of emotion that you feel an urge to change the topic, to find material that is more understandable.

Obviously, it is time to reconsider the diagnosis.

## Complex PTSD

PTSD is a diagnosis derived primarily from single isolated incidents. Resuming life after fleeing a traumatized society, however, is much more


4. van der Kolk, B.A. (1996). The body keeps the score: Approaches to the psychobiology of post-traumatic stress disorder. In B.A. van der Kolk, A.C. McFarlane & L. Weisaeth (Eds.). *Traumatic stress:The effects of overwhelming experience on mind, body and society* (pp. 214-241). New York: Guilford Press.

5. Briere, J. (2002). Treating adult survivors of severe childhood abuse and neglect: Further development of an integrative model. In J.E.B. Myers, L. Berliner, J. Briere et al (Eds.). *The APSAC Handbook on Child Maltreatment (2nd ed.)* (pp. 175-204). Thousand Oaks, CA: Sage Publications.

6. Chu, J. (1998). *Rebuilding shattered lives:The responsible treatment of complex post-traumatic and dissociative disorders.* New York: John Wiley & Sons, Inc.

## complex post-traumatic stress disorder

Problems in the following areas may result after experiencing totalitarian control, including sexual and domestic violence.

**affect regulation**–chronic depression, anxiety , self-injury, explosive anger, compulsive or inhibited sexuality

**consciousness**–amnesia for traumatic events, reliving experiences, feeling disconnected from one's self, losing track of one's identity

**self-perception**–helplessness, lack of initiative, shame, guilt, self-blame

**perception of perpetrator**–preoccupation with relationship with perpetrator, attribution of total power to perpetrator

**relations with others**–withdrawal and isolation, disruption in intimate relationships, distrust, inability to protect self

**systems of meaning**–loss of faith, despair

complicated. Complex PTSD is a term used by the psychiatric community to reflect the adaptation to trauma that arises from an accumulation of incidents. It might be a more meaningful framework for this case.[3-5]

Let's re-examine the symptoms from this angle.

The literature on traumatic stress describes fragmentation of narrative (story) when trying to put words to frightening memories.[3,6] The neurobiology of PTSD teaches us the biological basis for this: exposure to traumatic experiences is associated with "turning off" Broca's area, the part of the brain responsible for speech production. This experience is sometimes called "speechless terror."[4]

The depression and drinking need not be perceived as co-existing problems; rather they are part of the trauma. Using substances suggests she could be having difficulties regulating her emotions after surviving traumatic stress. The patient doesn't verbally report symptoms of numbing, but it is expressed in the matter-of-fact manner of telling about horrors.

The client's insomnia may be present because she doesn't allow herself to fall asleep for fear of terrifying dreams. Her poor self-esteem and chronic sense of guilt take on a different meaning considering that her basic trust in a society been grossly violated. Relations breaking down within the family is understandable in light of the inability to feel intimate and close to others after terror and betrayal.

To conclude: as health care professionals, we need to be aware that culture does influence our ability to make precise diagnoses. The best work is done when we maintain a nonjudgmental stance of respectful compassion.

# War Trauma in Refugees

## Red flags and clinical principles

Claudia María Vargas, PhD

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We know that the wounds from war are not confined to the battle field. Refugees from conflict zones often continue to experience trauma from persecution, imprisonment, torture and resettlement for a long time. Thus, it is important to understand the challenges of refugee families and communities.[2] This piece identifies some red flags for post-traumatic stress disorder (PTSD) according to age, gender and culture, and provides some guiding principles for mental health workers in caring for refugees.*

Psychological distress from war is harmful to refugee children and adults regardless of racial or cultural background. Refugees may experience a sense of helplessness and despair. The most common mental health issue for refugees is post-traumatic stress disorder and related symptoms of depression, anxiety, inattention, sleeping difficulties, nightmares, and survival guilt.[3-12]

### Red Flags

#### Age

Trauma can look very different across the developmental stages. Here are some of what we know are danger signs:

- **Birth to five years.** Young children have difficulty explaining their trauma, but display their trauma by clinging to their mothers, trembling and uncalled for crying. They may also show their trauma through play and inappropriate behaviours for their age like thumb-sucking, nail-biting, bedwetting, frightened facial expressions, fear of darkness or sleeping alone, and little social interaction.[13-14] According to the research, parents may not recognize possible trauma, because they mistakenly assume "the child wasn't looking when it happened" or "was too little to know."[9]
- **Six to 11 years.** Children at this age may become anxious, depressed, angry, unable to concentrate or socialize with peers, and may refuse to go to school. Others may experience sleeping difficulties, nightmares, fear of the dark, and physical ailments like vomiting, headaches or stomach aches. This age group is three times more likely to suffer from PTSD than adolescents, because they are at a younger stage of development.[15-16]
- **Adolescents.** Adolescents may be affected for a long time.[13] They can feel as if they are frozen in the past, with no prospect of a future.[17] Their trauma shows in school difficulties, eating disorders, alcohol abuse, teenage pregnancy, thoughts about suicide, or general 'acting out.' Most at risk are those who have lost family and community connections.[18]

"Traumatized people feel utterly abandoned, utterly alone, cast out of the human and divine systems of care and protection that sustain life. . . . When trust is lost, traumatized people feel that they belong more to the dead than to the living." [1]

- **Adults.** Traumatized adults tend to suffer from hypervigilance, emotional numbing and flashbacks or re-experiencing the trauma.[1] They may startle easily, show the fight-or-flight response or a heightened sense of awareness, and suffer from nightmares, emotional detachment from oneself and others, and distorted emotions and perceptions.[19-21] They may abuse drugs or alcohol, and become depressed, hostile and suicidal.

### Gender

Girls tend to internalize the trauma and become anxious, withdrawn and depressed. Boys tend to externalize trauma and are more likely to and be inattentive, impulsive and hyperactive, or to engage in violent activities.[19] However, findings are inconclusive regarding gender differences.

More important than gender, however, for youngsters is family separation, the murder of a parent (more likely to be the father, since more refugee men are murdered than women), parents' emotional well-being, experience of torture by a family member, or the number and intensity of traumas.[15-16,19,22]

### Culture

Findings point to commonalities in the human experience of emotional and physical pain and suffering across cultures.[23-25] The expression of trauma may differ: e.g., Soviets tend toward alcohol abuse,[26] while Ethiopians describe physical symptoms such as "burning all over, a tight feeling in the neck, and 'insects crawling under the skin.'"[27] Vietnamese have the think-too-much problem, and Latin Americans have "nervios" (nerves).[26] However, we need to be careful about stereotyping. The suffering is universal.

## Some Principles of Care**

### Multidisciplinary care

Refugees may have faced many health challenges, physical injuries, hunger, diseases and emotional trauma. It is essential to provide medical and mental health care, as well as the housing, schooling, and employment needs essential to life in their new homeland.

### Complementary therapies

Survivors of torture have been shown to suffer intense and prolonged pain, and they have a greater risk of developing chronic pain and other health problems.[28] Treatment of chronic pain from injuries that damaged nerves, muscles or bones may need more than one type of therapy, starting with medical care. Complementary therapies such as psychotherapy and body work appear to help the emotional and physical healing process.[28-29]

### Family-centred care

Since PTSD affects the whole family, it is important to learn its effects on all family members. Professionals who are family-centred are sensitive to the different ways families cope with loss and sorrow, and to their need to maintain their culture and language. These practitioners value cultural diversity and uniqueness across families and explore the need for community supports and reconnecting families with their cultural communities.[1,28-31]

### Strengths model

Refugees face many challenges—a different language, culture and world view—but they also bring with them many strengths. As survivors of persecution and cultural and family losses, they are motivated to succeed and create a better life for themselves and their children. Amidst the pain and trauma, clinicians need to recognize their strengths.[32]

### Cultural responsiveness

War trauma can affect future generations, as illustrated by the suffering of Indigenous and persecuted groups.[33-34] There is a need for cultural competence based on respect, trust, empathy, care and understanding of the socio-political and historical forces that led refugees into exile.[26,28-29,33] A culturally welcoming and safe environment is essential. Culture-sensitive care embraces cultural healing practices, including the role of spirituality and the mind–body–spirit connection.

**footnotes**

visit www.heretohelp.bc.ca/publications/visions for Claudia's complete footnotes or contact us by phone, fax or e-mail (see page 3).

**The essay is based on a review of international studies on PTSD in refugee children, complemented with interview data of service providers in Canada and the United States. The information gathered has been shared with respondents.*

*** The Vancouver Association of Survivors of Torture developed the VAST Therapeutic Principles of Care. See footnote reference 17.*

# Grief—Complicated? Or Not?

**Kay Johnson, MA, BHSc (Psychiatric Nursing), RN**

*Kay is the Director of Griefworks BC, a provincial bereavement resource and referral centre housed in the Children's and Women's Health Centre of BC. She has many years of experience working in mental health and in palliative care and now focuses on bereavement program development*

As a mental health worker and as a bereavement consultant, I have struggled to clearly understand if a griever is experiencing complicated grief—recognized by the medical community as a psychiatric condition[1]—or not. Is it complicated grief with already-present mental health and/or addiction issues? Or is it the natural expression of grief exaggerated by these issues?

## When does complicated grief occur?

I believe that complicated grief occurs when the death has added emotional trauma.

According to Dr. Therese Rando,[2] probably the leader on complicated grief, three situations can complicate grief when someone close dies:

- the death threatened their own survival
- the death is sudden and shocking, with mutilation of people other than a loved one
- the death is the traumatic and/or mutilating death of a loved one

## What is the medical view of "complicated grief"?

The medical community views complicated grief as a major depressive episode.[1] The bereaved person may think the sadness is 'normal,' but seeks professional help for relief of associated symptoms such as insomnia. A diagnosis of major depressive disorder is generally not given unless symptoms are still present after two months.[1]

The duration and expression of 'normal' bereavement varies considerably among individuals and/or cultural groups. However, the presence of certain symptoms, not characteristic of a natural response, may point to a major depressive episode. These symptoms include:[1]

- guilt about things other than actions taken or not taken at the time of the death
- thoughts of death other than feeling that he or she would be better off dead or should have died with the deceased
- feeling that everything bad happened because the survivor deserves it
- much slower thinking and physical abilities
- unable to do the usual tasks of daily living or job requirements
- hallucinatory experiences other than transiently hearing the voice of, or seeing the image of, the deceased person

Symptoms of avoidance, numbing, increased arousal, depressed mood, somatic or sexual dysfunction, guilt or obsession, addiction or other related symptoms may also be present.

## Is it? Yes or no?

I've seen all of these behaviours in people who didn't have a mental illness before the death and who didn't experience a complicated grief situation. Corporate presidents and school-age children find themselves unable to remember how to use the telephone. Those usually meticulous about their appearance wear dirty, wrinkled clothes. Some may say this is a major depressive disorder if it lasts longer than two months, as noted above. However, I know that sometimes it takes months for a griever to feel like they can get going with life again.

People with mental health or addiction issues have usually had many losses including secondary losses related to their illness: (e.g., loss of income, relationships, employment, status, self-esteem and/or control, and losses due to discrimination and/or victimization). Often, in this population, I have seen unsupported, unresolved loss through death early in life. Not dealing with this early grief is frequently the main reason there is a mental health condition and/or increased use/misuse of alcohol and other drugs.

## NOT necessarily complicated grief

Dr. Rando created a list of symptoms that are often mistaken for complicated grief, or incorrectly thought of as abnormal responses to loss.[2]

- Feelings or unresolved conflicts coming up from past losses that have or haven't been dealt with. This is a natural response for any griever. Often, a small loss triggers the feelings

**footnotes**

1. American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (DSM-IV-TR) (4th ed., text revision)*. Washington, DC: Author. Note: See under Bereavement (CodeV62.82); it is referred to as "Major Depressive Disorder."

2. Rando, T.A. (1993). *Treatment of complicated mourning*. Champaign, IL: Research Press.

## a definition of "complicated grief"

"...Criteria would include the current experience (more than a year after a loss) of intense intrusive thoughts, pangs of severe emotion, distressing yearnings, feeling excessively alone and empty, excessively avoiding tasks reminiscent of the deceased, unusual sleep disturbances, and maladaptive levels of loss of interest in personal activities."

Horowitz, M.J., Siegel, B., Holen, A. et al. (1997). Diagnostic criteria for complicated grief disorder. *American Journal of Psychiatry, 154*(7), 904-910. ajp.psychiatryonline.org/cgi/content/abstract/154/7/904

of past losses.

- Sadness is not the strongest emotion. Instead, it could be anger, guilt or frustration. There may also be physical reactions, such as sleep problems; social reactions, such as wanting to be alone a lot; or behavioural reactions, like sobbing frequently or constantly checking that the environment is safe.
- Feeling like a part of them died with their loved one or that something is missing from themselves. This may be more exaggerated if the loss had traumatic circumstances.
- Feeling sorrier for themselves than for the person who died, or seeming to continue the relationship by, for example, talking about the deceased in the present tense. Again, these are natural reactions.
- Keeping parts of the home as it was before the death to keep the memory alive. The bereaved person may continuously say or do things so that others will not forget the person who died. They may resist changing things that were in place before the person died, such as not wanting to move or take a new job.
- Worrying about the chance that they or other loved ones may die. Or being resentful that a bad person didn't die instead of this good person. They may get angry if they believe others are not grieving enough. These are common reactions in grieving.
- Experiencing temporary periods of intense, fresh grief long after the death. This is natural.

Those with complicated grief, however, may experience some aspects of mourning for many years, if not forever. They may also have a course of mourning that does not decline with time.

### A Challenge

The challenge of supporting a griever with a mental health issue and/or addiction is to be able to recognize the natural grief process for what it is. And to avoid enabling the griever to use their grief as an excuse for unacceptable behaviour. In the period after the death, the griever often has difficulty concentrating, gets frustrated more easily, and feels a loss of personal power or control. It's important to find ways to increase the griever's feelings of regaining control, but it's also important to maintain the healthy boundaries of responsibility for actions.

# Vicarious Traumatization

## An occupational hazard for helping professionals

My first job was at a transition house for women fleeing abuse. A co-worker shared that after years of working in the anti-violence field, she could no longer stand to watch violence on the news. I thought of her years later, when my husband and I were taking a walk around Stanley Park. My husband pointed out a man sitting alone in an area jam-packed with children and mentioned that he must be a kind grandfather. I had noticed the same man moments earlier, but I had targeted him as a sex offender. In that moment I grasped the extent to which my work with victims of sexual and relationship violence had influenced the way I see the world.

### Different names, similar experiences

It seems that Freud may have been on to something when he first identified countertransference. He viewed it as a condition that develops when therapists transfer their own unresolved issues onto their patients. Today, this term is more commonly used to describe the general emotional reaction a therapist has to a client.

For helping professionals who work with victims of trauma, their reaction to a client can be similar to the post-traumatic stress symptoms of a victim.

Researchers generally agree that these post-trauma-like reactions exist. There is, however, debate about naming and describing the experience. The terms secondary trauma, compassion fatigue, vicarious trauma and countertransference have all been used interchangeably, despite their differences.

Researchers identified secondary trauma in the 1970s by looking at emergency services workers who were repeatedly exposed to victims of trauma. The workers began to experience symptoms of post-traumatic stress disorder, such as nightmares and flashbacks.[1] In 1995, the term compassion fatigue was proposed to better described the "cost of caring" that counsellors paid.[2]

The concept of vicarious trauma developed through studying therapists who worked with victims of sexual violence. Researchers Pearlmann and Saakvitne believe that when we listen to the traumatic stories shared by clients, our view of ourselves and the world is permanently transformed.[3]

### How do we change?

The constructivist self-development theory aims to give a deeper understanding of the impact of vicarious trauma. The theory is rooted in the idea that reality is not something that is simply 'out there.' Instead, we construct our own reality based on our experiences. Thus, when we repeatedly experience exposure to traumatic material, it can change our perception of reality. Generally, these changes will occur in the following areas: [4]

- the framework ('lens') through which we see the world
- our self capacities, including our sense of self as worth loving
- our ability to get emotional needs met in relationships

Michelle Srdanovic

*Michelle has seven years professional experience supporting victims and survivors of trauma. She is pursuing an MA in Counselling Psychology at Simon Fraser University and works as a research assistant on a project addressing vicarious traumatization. Michelle plans to research how transition house workers manage vicarious trauma*

**footnotes**

visit www.heretohelp.bc.ca/publications/visions for Michelle's complete footnotes or contact us by phone, fax or e-mail (see page 3).

# Why Did This Happen? Witnessing tragedy

**Brian Chittock, DBA, CFRE**

*Brian is the Executive Director of Jessie's Hope Society, which is a member of the BC Partners for Mental Health and Addictions Information*

Vancouver's Celebration of Light fireworks festival will never be the same for me again. The memories I have of July 29, 2006, when China put on a spectacular fireworks demonstration, are of chaos, screams, sirens wailing—and the lifeless body of a young man I had just met a few nights before. He was lying in a pool of his own blood after jumping off the 18th-floor rooftop of my friend Alex's apartment building in Vancouver's West End.

It all began on Wednesday, July 26, 2006. A few friends had assembled at Alex's apartment for drinks and planned to watch the Italy's fireworks demonstration that night from the rooftop terrace. Most of the people knew each other. Timmy came later that night and brought his new boyfriend Jun, whom he had met a couple of weeks earlier. Jun, a handsome smiling young guy, joked around with all of us that night. He had only been in Canada for a few months studying English. He was from Brazil, which is where Timmy was from as well. The fireworks were amazing; we all had a lot of fun.

On Saturday the rooftop was packed with people from the apartment building and our group of friends to watch China's fireworks display. I had heard that Timmy and Jun had arrived and were on the roof with us, but I hadn't seen them. At the end of the show, there was a lot of commotion, with people trying to get down from the roof.

Suddenly I heard my friend Kirk screaming for someone to call 911, screaming that someone had jumped off the roof. He then yelled, "Brian, get over here now and take care of Timmy!"

Timmy was on the ground quivering and crying uncontrollably. I jumped over the fence on the roof, ran to Timmy and held him tight. I was in a daze. I continued to hold onto Timmy, who at this point was in shock. He was crying and mumbling that Jun had pulled away from him forcibly, run up to the edge of the roof and jumped to his death

Everyone was yelling and screaming. Police, ambulance and fire sirens blared. Helicopters circled above with their searchlights focused right on us. It was as if we were all in a movie, or a dream; as if none of it was real. All I could feel was horror. How could anyone jump off of an 18-storey building? »

*vicarious trauma* | *continued from previous page*

For example, if we hear many stories about violence, we may begin to see the world as unsafe. We may even feel fearful of trusting others, and this can affect our relationships.

**related resource**

National Clearinghouse on Family Violence. (2001). *Guidebook on vicarious trauma: Recommended solutions for anti-violence workers.* www.phac-aspc.gc.ca/ncfv-cnivf/family-violence/pdfs/trauma_e.pdf

### How can you recognize vicarious trauma?

**Visible changes include:**

- becoming cynical or losing hope
- avoiding social or work contact
- becoming fearful and overprotective because the world is seen to be dangerous
- setting rigid boundaries in relationships or, displaying a lack of boundaries and rescuing others
- abandoning spiritual beliefs

The emerging research suggests that those with a history of trauma are more likely to experience the greatest impact. Newer, less experienced counsellors, are also more vulnerable.[5]

- "I was terrified when my daughter asked to sleep over at her friend's house. Many of the children I support were sexually abused at a sleepover. I couldn't let her go."—*Victim Services Worker*
- "I wanted to work with women who have been abused, because I thought I could make a difference. Some days I lose hope—especially when I realize that nothing has changed in the five years I've worked here."—*Transition House Worker*
- "I just look at the world differently. When I see a mother who is critical of her children, I get upset and wonder if the child is abused. If I see a woman wearing sunglasses indoors, I think that she is hiding bruises from being beaten. This is stuff I never used to consider."—*Transition House Worker*

### Working toward solutions

The consensus is that vicarious traumatization is inevitable for those who work with trauma survivors. Yet we can address it and sometimes even prevent it by paying attention to our ABCs:[6]

- **A**wareness of our needs, emotions and limits
- **B**alance between our work, leisure time and rest
- **C**onnection to ourselves, to others and to something greater (i.e.,spirituality)

Research shows that the most influential resource is a group of peers that we can talk to about our trauma-related work.[7] So, how can we become involved in the support offered by our organizations? Clinical supervision, team meetings and chances to debrief are all valuable in helping counsellors stay connected.

Our clients change us forever; to honour them and ourselves, we must practice self-care.

How could Jun decide to die in such a violent way?

Slowly we got up and I took Timmy downstairs to find the police. Over the next two hours, in Alex's apartment, we all gave our statements to the police. They seemed unsure of what to do. There was so much chaos. And they seemed to be treating it as a homicide. We were stunned. We were even more stunned when they told us they couldn't provide us with counselling. We would have to deal with this horror on our own. Everyone was upset, crying, questioning, confused and angry.

No one could understand what drove Jun to such a tragic act. He was so young, vibrant and alive on the Wednesday when I first met him. How could he have done this to all of us? How could he have left us with this sadness, with all the unanswered questions? How could he have suffered so deeply and so alone, without trying to find a solution to whatever demons were inside him? What a tragic situation this was for us, Timmy, Jun's friends and, especially, Jun's family.

We later found out that Jun had left a note at Timmy's apartment. He had recently come out. He wrote about how being gay was causing him a lot of turmoil. He was unsure how to deal with his feelings—toward himself, toward Timmy. He didn't know how to deal with his family back in Brazil.

I felt so sad that he felt he had to endure this torture alone. I, too, have had some tough times and many times didn't feel I could go to anyone for support or help.

Today, Jun is still in my thoughts, but they are not sad thoughts any more.

> "It was as if we were all in a movie, or a dream; as if none of it was real. All I could feel was horror."

I think I will always have a helpless feeling when I think of him, because he never gave any of us a chance to help him. I can only hope that he's in a better, safer place.

**related resource**

SAFER (Suicide Attempt Follow-up, Education and Research) is a BC-wide service that works to reduce suicide risk among those in crisis, assist family and friends who care about them, and promote healing among those bereaved by suicide. People with concerns relating to suicide can receive crisis intervention by telephone, and anyone bereaved by a suicide death can access one-on-one counselling or support groups. Call 604-879-9251.

# Combat and Rescue

## Breeding Grounds for PTSD

Atholl Malcolm, CD1, PhD, RPsych

*Atholl is a clinical and consulting psychologist in private practice. Formerly the department chair of Psychology and Applied Leadership at Royal Roads Military College, he is currently an Adjunct Associate Professor at the University of Victoria. Visit his website at www.drmalcolm.ca*

From 1964 to the early '80s, I was an air navigator/tactical officer in the Canadian Forces. I was one of a large number of air crew trained and contracted to serve for five years. My goal was to finish this term, get my discharge gratuity and go to university.

In the middle of my stint, the rules changed and we were all offered a permanent commission. I accepted, but soon realized that a degree would help career advancement. Getting a degree in psychology seemed easiest to manage while being posted in different locations around the country—and I was interested in understanding human nature.

While taking this degree, I was flying with 442 Search and Rescue Squadron. In those days, emergency locator beacons were not very accurate. We would spend several weeks at a time looking for lost aircraft in British Columbia's unforgiving terrain and mountain weather.

I was taking a course in abnormal psychology at this time, and was particularly struck by a textbook chapter on traumatic stress and its effects. It seemed to apply to our environment and, especially, to the Rescue Specialists, whose job included parachuting into what can only be described as human carnage.

I recall one tragedy when five lives were lost in the crash of a light plane. While we were circling above, our specialists on the ground were getting ready to sort out the mess, place body parts into body bags, and so on. Then word came to wait until the coroner arrived on the scene. They had a long wait, guarding the scene and keeping bears away. When the coroner arrived, he took one look, threw up and left, telling our team to get on with it. A coroner had difficulty dealing with a scene that was commonplace to the Rescue Specialists.

### Old-Fashioned 'Therapy'

After a long day of searching, we would relax with a few drinks. If the search ended successfully, with lives saved, we celebrated; if there were fatalities, we drowned our sorrows.

Over time, it became ap-

parent that many of us were more comfortable around each other than at home with our families. Our crewmates understood why we stood around telling war stories, avoiding personal issues. We had a great sense of 'gallows' humour. Looking back, it is easy to see why there was high rate of family breakdown and other difficulties.

### A Second Career

After completing my doctorate in Clinical Psychology and 20-plus years in the military, I began a new career as a psychologist in private practice.

Regarding my 442 Squadron days, the circle is completed, as the old textbook predicted. In the last two or three years, my practice has assessed several of my former squadron colleagues for post-traumatic stress disorder (PTSD). These people are now retired, but due to the traumatic sights they were exposed to, some are badly affected. Fortunately, they are entitled to, and are receiving, much-needed therapeutic assistance from Veterans Affairs Canada.

## What is Trauma?

In my military day, Canada's involvement in peacekeeping was extensive, but active engagement in combat operations was rare. Now, a large number of Canadian troops are exposed to highly traumatic events. However, PTSD is not just a soldier's disorder. It also applies to assault victims and relief workers and police officers, and to anyone who is involved with others who have been traumatized.

There are three major components to PTSD. The first is increased arousal, which involves, for example, a heightened startle response and sleep difficulties. The second component can include re-experiencing the initial event when a reminder triggers a traumatic reaction. I treated one soldier who was triggered by the sight of a local soccer pitch, because an area of vegetation around it was similar to vegetation around a mine field in Bosnia. Other forms of re-experiencing include nightmares.

The third component is a strong desire to avoid anything that is a reminder of the event. So the PTSD sufferer will avoid social interaction in case someone brings up a topic of conversation that may trigger a reaction. Avoidance may also include avoiding or pushing away family members, because the heightened arousal causes inappropriate emotional reactions. This causes guilt and shame. So the sufferer, in an attempt to avoid hurting the people he or she loves, will spend hours in isolation—in the basement on the computer, for example. Or, they will spend excessive time with the colleagues who understand them because they are in the same boat—and it is often over a drink.

PTSD is an anxiety disorder. Alcohol, other drugs, gambling, sex and pornography are common avoidance behaviours, because they represent means of distracting from the anxiety. Depression is also a common side effect of PTSD.

## Treatment of the Traumatic Memory

Treatment can take several forms. All involve exposure to the original trauma and learning to cope with it.

When a person is exposed to a physical threat, it is the "fight-or-flight" centres of the brain that are activated. In this context, the event is not memorized in the true sense of the word. To explain: if we think of something that happened in the past, even an unpleasant event, we talk our way through the memory as we visualize the event, and we can choose at any time to distract ourselves. A traumatic memory lacks the cognitive or self-talk component, because there was a lack of cognitive processing in the first place. In the fight-or-flight response, our reaction is physical and more or less instantaneous: we either fight back or run away.

Brain scans have shown that when a person is subjected to something that triggers the original memory, the sites of the brain where verbal material is processed are relatively quiet compared to when someone thinks about a non-traumatic event. So, in therapy, by gently and gradually re-exposing a PTSD victim to the original trauma and helping the person stay with it while talking about it, we build the verbal component.

Once the verbal component is built, the person has an option to choose not to think about it. In this way, the instantaneous startle reaction is less likely to happen, and the person now has some control over it. A major fear in PTSD sufferers is lack of control, because that was inevitably a significant factor in the original trauma.

More than 50% of PTSD sufferers develop chemical or other dependencies. From a treatment point of view, it is absolutely necessary to treat these co-occurring problems together.

## Optimism for the Future

The good news is that following treatment, my friends from air force days are coping and their family life is

**related resource**

National Centre for PTSD, US Veteran Affairs: www.ncptsd.va.gov

improving. There is now a much greater understanding of brain chemistry and this very real disorder. "Shell shock" and "lack of moral fibre" are terms that have been placed where they belong—in the trash can.

We can now provide therapies that work. It is my experience, however, that many PTSD sufferers are reluctant to seek help. So it often up to a family member to take the first step. I have seen many clients who came only because their marriage was on the line if they did not. Nevertheless, they entered the therapeutic door, and that is a major step.

# When the One Responding to Traumas Faces His Own

## A Paramedic's Story

Richard Voigt

*Richard is a former paramedic*

### Surreal

My journey into the world of mental illness started in February 2000 with an ambulance call that should have been a routine affair: a patient was in cardiac arrest.

There was something different, for me, about the way I took in the scene as we arrived. The patient was lying in a crosswalk and a fishing rod and tackle box were sitting by the curb, some distance from a river. But things seemed oddly out of place…

My shift partner and I started to work on the patient immediately and were quickly backed up by the Advanced Life Support (ALS) team. As we worked, the scene became surreal. It was like I was watching everything from above—and I still couldn't make sense of what I saw. When it came time to defibrillate the patient, I just kept on ventilating him—registering the call to clear, but unable to act. My partner had to get me to stop.

The ALS attendants took me with them to the hospital, which wasn't usual; I was the driver and usually drove the ambulance to the hospital… When they spoke to me after the call was completed, I felt like a robot replying, and the sensation of exhaustion was overwhelming. A hospital doctor that I knew told me to see my physician.

My family doctor sent me to a counsellor, but it was clear I needed more help. My coping mechanisms weren't working. I was getting angrier and dwelling on calls I had done. My union representative suggested I see a psychiatrist specializing in post-traumatic stress disorder (PTSD).

The psychiatrist gave me good news and bad news. The good news was that he was able to verify and explain why I had PTSD; it was a relief to have some understanding of what was going on. Then the bad news: he said I shouldn't return to my job, as my stress was work related. I was devastated. On the advice of a co-worker I filed a Workers' Compensation Board (WCB) claim.[1]

### Paramedic 'real'

Having been a paramedic for 12 years, I had seen some horrific calls. Calls involving children stand out: I found it hard to accept or make sense of a child dying. Also, witnessing someone realize that their life has been altered is not pleasant, even when you've seen it a few times.

Thankfully, I can still count on my hands the number of really disturbing calls. Contrary to what one sees on television, our days are generally quiet. Really intense calls happen just a few times a year, but the rest tend to be calls in which you know what to expect.

However, 1999 had been a stressful year, with a higher number of critical incident calls than usual. I had attended to a fireman and three police officers. I had also attended to two co-workers and had resuscitated a friend's daughter. When the case is close to home, it is particularly difficult emotionally.

I had an extremely upsetting experience in September 1999. My partner and I were trapped on a call at a domestic scene where weapons were involved, and at the same time I was hearing over the radio about my friend and co-worker being attacked on the job. And it brought back memories from almost 20 years prior, of dispatching taxis while a cab driver was being murdered. I really began to feel out of sorts after that day.

Prior to the 'fisherman' call, I had increasingly been having problems sleeping and had pain from clenching my jaw. My mood was changing. I got angry when driving. I felt wound up all the time. I didn't want to go to work any more. But my employer hadn't provided training in recognizing the signs of job-related stress. My wife and I had separated; I thought it was the stress of the separation that was getting to me.

But things seemed oddly out of place… As we worked, the scene became surreal. It was like I was watching everything from above —and I still couldn't make sense of what I saw.

### footnotes

1. Workers' Compensation Board of BC changed its operational name to WorkSafeBC in July 2005; however, the legal name remains the Workers' Compensation Board of BC.

2. Canadian Mental Health Association, BC Division. (2003). *Navigating workplace disability insurance: Helping people with mental illness find the way.* See cmha.bc.ca/advocacy/insurance for more detail of Richard's WCB journey (under the pseudonym, Peter).

### WCB: Compounding the stress

Once I had filed with WCB, things quickly went really bad. WCB denied my claim, saying that trauma from my time as a ward of the Alberta government was the cause of my mental health condition. And any possibility of working in any form in health care was denied me by a psychologist I had never spoken with.

I had been taken into care at age 12, because my adoptive parents became ill. It was a trying time, and I did become very rebellious; consequently, I was maltreated. But I never suffered any mental health issues. WCB had no evidence that my time as a ward had affected my job. And the psychiatrist's opinion was that the PTSD was job-related.

The WCB Review Board determined that I had sustained injury from my employment as a paramedic and awarded permanent partial disability and retraining. I filed a complaint with the BC Human Rights Tribunal (BCHRT) in 2003, alleging discrimination based on family status and type of injury.[2] This, however, began a whole new struggle—and what I believe was retaliatory action on WCB's part.

I was inappropriately retrained and placed in a truck-driving job. I had been showing signs of road rage and, with minimal training, was expected to drive a semi-trailer through the Lower Mainland. And the prolonged sitting and heavy lifting aggravated previously documented back injuries (two herniated discs that were also later confirmed by a CT scan).[3] I've also been forced (threatened with loss of income) to drive when experiencing problematic reactions to psychiatric medication (Moclobemide).

WCB responded by trying to have the case dismissed, arguing that my attempts to gain justice removed responsibility from their jurisdiction.[4] In November 2005 I filed a Notice to Admit in BC Supreme Court, presenting all the facts of the case.[3] WCB made no reply within the requisite 14 days, so my statements are legally deemed to be the truth. And in April 2006 the BCHRT denied WCB's bid for dismissal of the case.[4]

WorkSafeBC (what WCB is now called) still fails to acknowledge that the evidence—which their counsel did not oppose—supports my claims of mismanagement and failing to consider my safety. And they continue to force me to drive truck.

Fighting this worker compensation claim has been incredibly stressful. Seeking help can, it seems, actually cause more harm than the original injury.

It really affected my psychological frame of mind to have my doctors say one thing (that my stress injury was work related) and WorkSafeBC say the opposite (that it wasn't work related). Being forced to work in an inappropriate vocation by the agency charged with the protection of workers was too much for me. I got to the point where I was not only suicidal, I believed WorkSafeBC was trying to kill me. That they refuse to correct their errors I find unbelievable.

When my back injury got to the point where I needed medication for the pain, my doctor' locum wanted me committed; she thought I was delusional, because I said that WorkSafeBC forced me, with my history of back injuries, to work in this vocation they had chosen for me. No, they would never do that!

Now I'm dealing with the BC Ombudsman. On and on it goes…

3. Voight vs. Her Majesty the Queen in Right of the Province of British Columbia and the Workers Compensation Board of British Columbia [et al], 2005, Notice to Admit, case no. L94497, filed in the New Westminster Supreme Court of BC registry.

4. Voight vs. Workers' Compensation Board, 2006 BCHRT 190, RSBC 1996, c.210 (as amended). www.bchrt.bc.ca/decisions/2006/pdf/april/190_Voigt_v_Workers_Compensation_Board_2006_BCHRT_190_pdf.

# I might be nothing
## Journal writing

Lara Gilbert

*Lara was educated in Vancouver, British Columbia, receiving her BSc (Honours Biochemistry) from the University of BC in 1995. Lara took her own life in 1995 and her journals were published nearly a decade after her death*

**July 18th, 1993**

I've heard the opinion, in general and with regard to myself personally, that people abused as children often develop depression as adolescents or adults. I don't argue with that theory at all, but I think my ideas about depression fit in perfectly with this cause-effect hypothesis. The fact that my grandfather forced me to have oral sex and anal intercourse with him, and that my father fondled and raped me until I got the guts up to move in with my mom—these events pretty well tore those rose-coloured glasses off me and allowed me to see the real world, early on.

Some people speak of lost innocence, but if anything was lost, it was the ability to close my eyes to the negative aspects of our existence—I mean existence in a collective sense—us as a species, as a planet, as a solar system, as a/the universe. Innocence is a delusion, but a necessary one. Maybe my eyes are wide open to everything, but the effect of this has been to incapacitate me. Instead of facing the challenges life presents, I've lost motivation and energy and interest, while still being aware that those challenges are there. I feel guilty for not even putting the effort into the small things—I can't even do the laundry and cook, let alone organize my life and contribute in some way to society. All I've been doing is taking, taking, and here I am again in the hospital, taking up a bed and nurses' and doctors' time and causing worry and pain for my mom. I'd be better off dead, and I wish my family would understand this so that when I am successful with my suicide, I won't have caused them even more problems… […]

**December 16,1993**
**Age 21**

I am so enraged at the people with power, usually male, who get away with anything; and at the

*Excerpts are reprinted with permission from* I might be nothing: Journal writing *by Lara Gilbert. Abridged and edited by Lara's mother, Carole Itter, 2004. The book is available from Trafford Publishing at www.trafford.com or from Carole directly at critter@vcn.bc.ca*

justice system that turns a blind eye while other people suffer.

I wonder what to expect will happen next month at the sexual assault hearing involving that male nurse. Even without my full medical records documenting my dissociative experiences, post-traumatic stress disorder and my brush with prostitution—which gives the defence plenty of material to come up with reasons I might not be telling the truth—even without all my previous allegations of my grandfather, father, and the rape of last November, they could pretty easily acquit him with the "reasonable doubt" criterion. It's my word against his, and my word will not count for anything.

I will get to speak, at least. I will be able to tell the truth about his attempt to seduce me and his subsequent rape of me after failing at the seduction. The truth. No one in the courtroom has to believe me, and many probably won't. But being believed is a lot harder to achieve than I used to think.

My dad still strongly denies that he abused me. I got a letter from my half-brother saying he wanted to help however he could; he wanted to be my big brother. He couldn't make the choice of whose story to believe, but he feels for how I've suffered, and he says his relationship with our father has been strained for the last five years. My father makes it hard not to believe him, my half-brother says.

I can imagine; he's a natural arguer. It's good to know that my half-brother is supportive of me anyway. But it still boggles my mind how most of that family is trying to ignore the issue. Grandma practically admitted to me in her letters that she is aware of what happened. But no one will hold my dad responsible for what he's done. It's me, not him, who's left the family circle. […]

### July 8, 1994

I wonder if I'll ever enjoy sex again. It's hard to imagine those feelings ever returning to my body, after thinking about this upcoming preliminary hearing. The defence lawyer is going to try to make me look like a slut, a whore—and one with a mental disorder. I dread the inevitable questions regarding my (slim) experiences with prostitution. The Crown prosecutor has warned me that this will definitely be brought up, and his objections may be overruled so I must be ready to go into the "story."

The way the male nurse asked me to have intercourse with him and later to give him "a blow"—I felt like I was a prostitute whose services were being requested. It was so demeaning. So I told him that I'd had experiences in the past involving unethical sexual relations and that it was damaging. I was hoping to dissuade him from continuing his disgusting line of "conversation" with me, but it didn't change his mind, and now that submission of mine gives strength to his side of the story by letting everyone known something humiliating and demoralizing about me that they need not have found out about, if I'd kept my mouth shut that day in the hospital. My worst fears are not that my history will throw my credibility out the window (although this would be painful and angering) but that Bob and Jan (who both plan to come to the hearing) will come into the courtroom despite my insisting that they remain outside the room. I said I would be more nervous if I saw anyone in there I knew.

If my boyfriend and best girlfriend find out what a slut I've been, I don't think I'll be able to stand the humiliation. I'll feel like less than a real person. And if in court I'm asked why I tried prostitution, I'll just have to admit that no, it wasn't for the money—I wasn't penniless or wired on drugs—it was because I longed for a sense of power and control that was lacking in my life. Offering myself to men for a price gave me a feeling of worth and importance, and an exchange that was business-like and for me, unemotional. "Safe" sex. The power and worth, of course, are illusions. The defence attorney is going to ask how I could be so stupid or mixed-up not to realize that from the beginning. And how can I expect to be believed that the male nurse raped me when the court knows I was a whore, and whores always want it, right?

I'm fed up with being female. And frigid.

Anyhow, aside from the above stresses, things are going quite well for me.

Offering myself to men for a price gave me a feeling of worth and importance, and an exchange that was business-like and for me, unemotional. "Safe" sex. The power and worth, of course, are illusions.

I love my job, I love feeling like I'm doing something worthwhile, and working in the same hospital that gave me back life back last year. And I love these hot summer nights. The realization is gradually sinking in that despite the challenges and difficulties ahead, I am ready to deal with them—with anything. I know how to fight, and with my mood solid as a rock. I can plough my way through whatever tough times I run into. It's hard to accept this because it gives me no excuse to give up, give in. If I am capable of surviving, I simply must survive….

**March 4, 1995**

I'm actually optimistic; I just can't stop crying. This has been the hardest week I've had—well, maybe not ever, but one of the top five of my hardest weeks ever.

Testifying was difficult, the cross-examination being much more grueling than at the preliminary hearing last July. But I was prepared. I've been watching all the proceedings and I feel like I'm living in that courtroom. I don't want to miss a minute of it, because I want to know exactly why the jury makes the decision it eventually makes. I sit there at the back, watching the witnesses answer the lawyers' questions, watching the judge at His Lordship's desk, watching the expressions on the faces of the jury, staring at the back of the accused's head in the prisoner's box. When I can't stand to look at anyone, I stare at the royal crest on the wall above the judge's head, and pray to God and to the justice system in Canada. I've decided to believe in both this week.

There have been ups and downs—the Crown and my lawyer were successful at the disclosure hearing in preventing any of my medical records from being entered; the defence lawyer is very good at what she does, and has pointed out some inconsistencies in my statements to the police, as well as focusing relentlessly on my prostitution issue. (I dreaded this—the humiliation I feel while listening to her belittle me publicly is overwhelming).

When the video of the male nurse's confession (that is, to "consensual" sex to the police was played for the court, I started feeling much better. He is one twisted man, verging on psychopathic, and I think this is very apparent to the jury.

The problem remains that it is unclear (from a legal point of view) whether I consented to sex, because I just "allowed it" and cried while he raped me in my hospital room. If the Crown can apply one of the laws involving sexual relations with a person in the position of authority or caregiver, this will help. But from the arguments I've been listening to between the lawyers, the law is very vague regarding a situation like mine. Perhaps this case will set a precedent.

**March 12, 1995**

Last Wednesday night at 9 pm after 16 hours of deliberation over two days, the jury announced their verdict: Not guilty.

Hearing it was crushing. It felt like telling me I had not been raped; I made a fuss over nothing; I wanted to have sex with a strange man while committed to psychiatric unit because of suicidal and dissociative thoughts.

It still hurts me to think of this verdict, although the Crown has assured me that the jury believed me; they did not like him at all. They sympathized with me and wanted to be able to convict him. The problem was the law.

I did not resist the assault (after declining, in our conversation about ethics) because I implicitly trusted he would not assault me; he was in a position of authority, and his breach of trust was shocking and overwhelming to me so that I felt frozen. I managed to retreat into the bathroom and eventually to say "Stop it, stop, it hurts." But in the eyes of many people, including the judge, the defence lawyer, the accused and at least some of the jurors, I allowed the rape to occur.

For the sex to have been nonconsensual, the law says he must have "exercised his authority" (not enough evidence he exercised it, whatever that means) or been "reckless or willfully blind" by failing to take the necessary steps to ensure I was consenting. (Defence argued that he did take these steps and I agreed to sex—in fact, said "Okay, where can we do it?")

The justice system does not work. The resolution I expected to feel at the end of this trial is missing.[…] i

# Post-Traumatic Stress Disorder

## Choosing the treatment that is right for you

Post-traumatic stress disorder (PTSD) is a common condition that sometimes arises after a person has experienced a traumatic event such as sexual assault, a natural disaster or combat. Some people with PTSD are unable to hold a job or socialize with friends, because they are so seriously affected by the disorder.

People suffering from PTSD are confronted with a bewildering array of treatment options. To add to the confusion, some practitioners make dramatic claims about the effectiveness of their treatments, often without any supporting evidence. The following are some scientifically supported recommendations for choosing among treatments. (Detailed reviews of treatment approaches appear in the related resources and footnotes sections at the end of this article.)

The first step is to get an evaluation from your family doctor. Your doctor might also decide to refer you to a clinical psychologist or psychiatrist for further evaluation. An important part of the assessment process is to decide when it is appropriate to begin PTSD treatment. Some people with PTSD also have other problems, such as severe depression or a serious drug or alcohol problem. These problems might need to be addressed before treating the person's PTSD.

If the time is right for you to be treated for PTSD, then there are several options. The two leading, scientifically supported treatments are cognitive-behavioural therapy (CBT) and particular types of medication.[1-2]

### Cognitive-behavioural therapy

CBT is a form of psychotherapy, typically provided by a clinical psychologist. The goals of treatment partly depend on your particular symptoms and problems, and your specific goals. CBT typically involves teaching you ways of improving your coping skills (e.g., breathing exercises or particular types of relaxation training), along with ways of helping you become less frightened of harmless, but fear-evoking things in your life. CBT can also reduce other PTSD symptoms such as recurrent nightmares.

To illustrate, Alison was tormented each night by terrifying nightmares of a sexual assault that happened several years ago. During her CBT sessions, Alison worked at desensitizing herself to the nightmares by writing a vivid description of the sexual assault and reading it over and over, until it became boring. This and other CBT methods gradually reduced the frequency of Alison's nightmares.

### Medications and CBT

There are several different types of effective medications for PTSD. These include a class of drugs known as "selective serotonin reuptake inhibitors," such as Prozac, Celexa and Paxil. The choice of medication often depends on the specific nature of your problems. These medications are typically prescribed by a psychiatrist or sometimes by a family doctor.

CBT and medications are equally effective for the average patient. However, for reasons that are currently unclear, some patients benefit more from one treatment than another. Your family doctor or mental health professional (i.e., psychologist or psychiatrist) can help you decide which treatment option is likely to be best for you. People with particularly severe PTSD may require a combination of treatments, such as CBT plus one or more medications.

CBT and medications are effective in treating children and youth with PTSD, although over the past few years there has been some concern that certain medications, such as the serotonin reuptake inhibitors, might increase the risk of suicide. These harmful effects appear to occur in only a minority of patients—possibly those with a history of impulsive, self-destructive behaviour. Not all clinicians are convinced that these medications have these harmful effects, so the issue remains controversial. Health Canada advises that patients (or caregivers) consult the treating physician to confirm that the drug's likely benefits outweigh any risks.

### Be aware

There are many other treatments for PTSD, although there is little evidence that some of these treatments are useful, and for other treatments the claims of their effectiveness have been exaggerated.

- Eye Movement Desensitization and Reprocessing (EMDR) – may be helpful in some cases[1-2]
- Hypnosis – little evidence that this is effective[2-3]
- Psychoanalysis – little evidence that this is effective[2-3]
- Thought Field Therapy – no evidence that this is useful[4]
- Neuro-Linguistic Programming – no evidence that this is useful[4]
- Emotional Freedom Technique – no evidence that this is useful[4]
- Critical Incident Stress Debriefing – no evidence that this is useful for preventing PTSD; indeed, some evidence suggests that some forms of debriefing may be harmful[1-2]

**Steven Taylor, PhD, ABPP**

*Steven is a Clinical Psychologist and Professor in Psychiatry at the University of British Columbia. He has published over 180 scientific journal articles and book chapters, and 12 books, primarily on the nature and treatment of anxiety disorders*

**footnotes**

1. Taylor, S. (2006). *Clinician's guide to PTSD: A cognitive-behavioral approach.* New York: Guilford.

2. National Collaborating Centre for Mental Health. (2005). *Clinical Guidelines 26: Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care.* London, UK: Gaskell and the British Psychological Society. www.nice.org.uk/page.aspx?o=CG026fullguideline.

3. van Etten, M. & Taylor, S. (1998). *Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis.* Clinical Psychology and Psychotherapy, 5, 126-145.

4. Devilly, G.J. (2005). *Power therapies and possible threats to the science of psychology.* Australian and New Zealand Journal of Psychiatry, 39(6), 437-445.

### Inform yourself

When choosing a treatment for PTSD, it is important that you take the opportunity to learn about the treatments being proposed. Check out the references and websites at the end of this article. Ask your doctor or therapist about the scientific evidence for whatever treatment is being proposed. Part of overcoming PTSD involves becoming more empowered. This starts with you making informed choices about the treatment you are willing to receive.

related resources

Matsakis, A. (1996). *I can't get over it:A handbook for trauma survivors (2nd ed.).* Oakland, CA: New Harbinger.

Taylor, S. (2005). *Post-traumatic stress disorder.* www.anxietycanada.ca/PTSDEn.pdf

Visit our **www.heretohelp.bc.ca** for our web-only article titled "Medication Treatment of Post-Traumatic Stress Disorder" by Joseph Wang, MD, PhD, Wei Zhang, MD, PhD and Jonathan Davidson, MD.

# Post-Traumatic Stress Disorder—and Traffic Crashes

John Vavrik

*John is a Consulting Psychologist with ICBC, focusing on the application of research on psychological issues arising from motor vehicle accidents—in particular, assessments, risky driving behaviours and crash prevention. Also a Registered Psychologist in private practice, John specializes in educational, vocational and disability-related assessments and therapeutic interventions*

Pat is running late. She can barely wait for the light to change. When it does, she instantly accelerates across the intersection. In a split second she is engulfed in a wave of deafening noise, ripped out of her seat and smashed against a wall of shattering glass, with metal and limbs spinning around violently. Her senses all seem in overdrive yet her mind is blank. Pat feels like she's watching a film in slow motion. She watches passively as her car rotates in the air, landing on its roof. Hanging upside down in the overturned vehicle, she can see its underbelly as if watching it from above. Later she learns that she is actually looking at the chassis of the truck that smashed into her. Despite the high speed impact, Pat lives, suffering only non-life-threatening physical injuries.

Motor vehicle crashes, in addition to being one of the top causes of death and injury in Canada and around the world, can sometimes trigger or worsen existing psychological conditions. These conditions may include anxiety, depression, anger, grief, guilt, travel phobias and post-traumatic stress disorder (PTSD).

If Pat were to develop PTSD, she may suffer from insomnia. When she does sleep, she may "re-experience" the crash in nightmares. She may try to avoid driving, particularly through intersections, fearing another similar crash. When she does drive, she is likely to constantly check and recheck all cars, buses and trucks (especially the trucks)—to the point of being worn out by the intense, indiscriminating watchfulness (i.e., hypervigilance), which can actually cause her attention to drift.

## Will Pat develop PTSD?

The good news is that simply being in a crash, even a serious crash, will not automatically afflict Pat with PTSD. In fact, the odds are generally in her favour.

Only about one in 10 individuals who describe their collision as "traumatic" actually develop PTSD. Most crash victims recover within a few months; however, some continue to report chronic symptoms of post-traumatic stress, which hinder their psychological and physical recovery.

Of those who do develop some PTSD symptoms, most recover within the first year. About half of those meeting PTSD criteria at one year following the crash recover by the end of the third year.

The relationship between crashes and PTSD is not simple because it depends on the type of crash, the type of individual involved, as well as on the social, economic and legal issues that emerge following a crash. While the severity of Pat's crash may put her at greater risk of PTSD, how she perceives the crash will likely play an even larger role.

"Traumatic" crashes are often described as sudden, unexpected, unpredictable, uncontrollable and scary. Crashes seem to be more stressful when the actions of other drivers are perceived to be intentionally directed at the victim (such as in road rage incidents), when the driver feels responsible for the crash, when close friends or family are in the vehicle, and when someone is trapped in the vehicle after the crash.

Pat's history with other traumatic events, including other crashes, as well as pre-existing conditions such as anxiety, emotional problems, depression and excessive health concerns also influence her risk of developing crash-related PTSD.

How she responded emotionally during and immediately following the crash is also relevant. If her reaction suggests some type of dissociative experience, such as feeling numb, dazed or watching the crash from the outside looking in, she may be at a greater risk of PTSD.

The way she "processes" the crash (i.e., how she appraises or interprets the

only about 1 in 10 individuals who described their collision as "traumatic" actually develop PTSD

footnotes

1. Taylor, S., Thordarson, D.S., Maxfield, L. et al. (2003). Comparative efficacy, speed, and adverse effects of three PTSD treatments: Exposure therapy, EMDR, and relaxation training. *Journal of Consulting and Clinical Psychology*, 71(2), 330-338.

2. Rabe, S., Maercker, A., Zollner, T. et al. (2006). Neural correlates of post-traumatic growth after severe motor vehicle accidents. *Journal of Consulting and Clinical Psychology*, 74(5), 880-886.

event in the context of her emotions and actions at the time) might affect how she forms an autobiographical memory of the event, which might in turn enable more involuntary "flashbacks" of the crash as time goes on. If her memory of the crash is disorganized or fragmented, she is also more likely to experience PTSD.

Pat might also be more at risk if she views any intrusive thoughts and memories of the crash negatively (e.g., "I'm going out of my mind" vs. "These are just uncomfortable but temporary thoughts I am willing to accept for now." She would also be at greater risk if she used common (and often natural) coping strategies that actually promote the maintenance of PTSD symptoms—for example, if she tried hard to suppress all intrusive thoughts, ruminated about the crash, or dwelled on why the crash happened to her specifically. (Try as hard as you can not to think of a big black truck that is about to hit you).

If Pat receives very little support from her friends and family, if she has financial difficulties and if she becomes involved in a legal case, she will be more likely to develop and maintain PTSD. Legal action, with its emphasis on psychological injury rather than recovery, has particularly been shown to be a risk factor.

Finally, although we have focused on Pat, the driver, it is important to remember that post-crash stress reactions can sometimes develop in people who simply witness a traumatic crash. This is one reason care must be taken in designing prevention programs that use mock accidents to raise awareness of crash consequences.

### Treatment and outlooks

If Pat does develop full PTSD, there are many effective therapies available:

- Exposure therapy appears to be effective in reducing the re-experiencing symptoms and travel phobias[1]
- Relaxation therapy may be especially useful for managing hypervigilance[1]
- Eye movement desensitization and reprocessing (EMDR) therapy has also been shown to reduce PTSD symptoms[1]

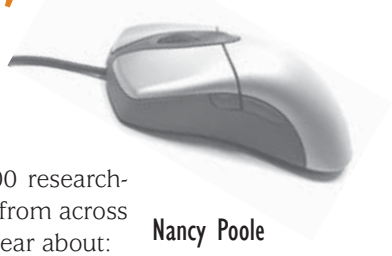
Recent research also confirms what many crash victims have been saying for years: confronting a life-threatening event like a motor vehicle crash can lead to very positive psychological changes. Pat may experience such "post-traumatic growth" if she begins to re-evaluate her priorities in life, build more meaningful relationships with friends and family, and gain strength and confidence from her difficulties.[2]

### Prevention

The simplest way to reduce the negative psychological impacts of crashes is, of course, to prevent crashes in the first place. Simply checking for cross traffic before entering the intersection, even if the light was green, might have been Pat's most effective strategy for eliminating the risk of crash-related PTSD.

# Connecting Virtually

## Webcast on women, violence and substance use



Nancy Poole

*Nancy is a Provincial Research Consultant on Women's Substance Use Issues with BC Women's Hospital and with the British Columbia Centre of Excellence for Women's Health. She works on research and knowledge exchange relating to policy and services for women with substance use problems*

In the last week of September 2006, 200 researchers, policy makers and service providers from across Canada met "virtually" in a webcast to hear about:

- connections between women's experience of violence/trauma and substance use problems
- developments in reducing the "mystifying separation"[1] between anti-violence and addictions services
- models for discussing substance use with women who have experienced violence
- models from BC, Canada, UK and US that provide in-depth, integrated support
- information helpful for women who are examining their own substance use following an experience of violence
- other implications for research, policy and work with women

The webcast format allows many people to participate simultaneously. You view the presentation on your computer screen and hear the presenters through your computer speakers. And you can type in questions for the presenters. Responses, questions and information on this topic of violence and substance use connections rolled in from interested participants from coast to coast.

The content shared in the webcast (and summarized below) was the consensus of 20 women who work in violence- and addictions related agencies, and in research and policy contexts. These women had participated in a virtual "community of practice" over a four-month period from April through July 2006. This virtual community and the webcasts are part of a larger project entitled Coalescing on Women and Substance Use: Linking Research, Practice and Policy.

### Compelling Connections

Women's substance use is strongly associated with their experience of violence, abuse, assault and trauma. For example, alcohol problems are up to 15

### footnotes

visit www.heretohelp.bc.ca/publications/visions for Nancy's complete footnotes or contact us by phone, fax or e-mail (see page 3).

### want to know more?

The cross-country webcast media file is available on request. Five information sheets designed to extend the discussion and action on this important issue will be posted on these project sponsor websites:

- BC Centre of Excellence for Women's Health: www.bccewh.bc.ca
- Canadian Women's Health Network: www.cwhn.ca
- Canadian Centre on Substance Abuse: www.ccsa.ca

Five more virtual learning communities on women and substance use issues are being planned as part of this project. For information contact Nancy Poole or Katja Clark by e-mail at kclark2@cw.bc.ca, or phone 604-875-2424, Ext. 6488.

# Somatic Experiencing Therapy
## 'Unfreezing' the trauma response

Amanda Sawatzky, MEd, CCC, SEP

*Amanda holds a degree in Psychology, a master's degree in Counselling, a certificate in Conflict Resolution and is a certified Somatic Experiencing practitioner. She works both in private practice and for Cowichan Lake Community Services*

Somatic Experiencing (SE) is an approach for working with and healing trauma. It was developed by Dr. Peter Levine,[1] who holds a doctorate in both medical biophysics and psychology. Dr. Levine took his observations from both these fields and tried a new way of working with people that has had amazing results.

### Animal instinct: fight, flee or freeze

Levine researches animals in the wild. Animals have a reptilian brain and act purely out of instinct to survive. When animals feel threatened, they have three choices of action that help them survive: to fight, flee or freeze. All will help the animal stay alive.

For instance, a cat who is being approached by a large dog will evaluate the area and decide if it has an escape route. If it does, it will flee—and burn off all the adrenalin pumping through its body as a result of fear. If there is no escape, the cat may fight. This will also burn off the adrenalin. If the cat decides the dog is far too large to fight, it may freeze. In freezing, there is a surge of chemicals in the animal's body that slows the respiratory system, the heartbeat and all other functions. The system is basically 'shut down,' and the animal is immobilized.

The key with the freeze response is what happens afterward. Let's say the dog decides not to go after the cat any more and goes away. Since animals »

*connecting virtually* | *continued from page 25*

times higher among women who are survivors of intimate partner violence than in the general population.[2] Girls who experience physical and sexual abuse by dating partners are 2.5 times more likely to be smoking heavily within 30 days.[3] Mothers who have children with fetal alcohol syndrome have serious histories of abuse and partners who don't want them to quit drinking.[4]

### Service silos

In spite of the strong relationship between substance use and experience of violence/trauma, few service agencies have philosophies and visible services that integrate assistance to women. Many anti-violence services restrict access to women who have substance use problems. In addition, women seeking help with violence concerns have received conflicting information about the nature of substance misuse and its connection to woman abuse/trauma, and about treatment and support options.

### Integrating support

Service providers recognize that there are many roads to change or recovery.[5] For women with substance use problems, a key step in their growth may be to explore how substance use is connected to experiences of woman abuse, early childhood trauma or other forms of gender-based violence. We need to create contexts for integrating this knowledge into both anti-violence and substance use services.

Resources for supporting discussion of substance use problems by anti-violence service providers were discussed. It was pointed out how safety planning can be useful as a common theme for providing support. Many anti-violence services, such as the Phoenix Transition House in Prince George and Atira Women's Resource Society in locations throughout the Lower Mainland, have found ways of making it safe to talk about one's substance use in the context of their services.

### Seeking safety

Anti-violence services have also identified the need to provide more in-depth support for women experiencing trauma and substance use problems. For example, service providers at the Victoria Women's Sexual Assault Centre (VWSAC) observed that women with trauma-related and substance use problems are often in crisis. They rotate through services, unable to get their complex issues addressed.[6] In response, VWSAC staff, in collaboration with other community providers, are offering integrated treatment groups that utilize the Seeking Safety model[7-8] as a foundation.

For women, care systems have often failed to recognize the overlap between violence, substance use and mental health problems, so haven't provided integrated support and treatment. Anti-violence services, though, are increasingly rising to the challenge of providing such integrated support.

Policy and research that articulate and support this integration are much needed. Virtual learning communities have a role in facilitating researchers, program providers and policy makers to come together to engage with the issues and be inspired to act on promising strategies.

The Coalescing on Women's Substance Use: Linking Research, Practice and Policy project is sponsored by the British Columbia Centre of Excellence for Women's Health, co-sponsored by the Canadian Women's Health Network and the Canadian Centre on Substance Abuse, and funded by Health Canada under the Drug Strategy Community Initiatives Fund.

related resource

Seeking Safety: www.seekingsafety.org

naturally know how to discharge the chemicals and energy that has built up, the cat will shake and tremble to effectively burn them off. And then the cat will go on its way, basically no worse from the experience.

Humans, too, have this reptilian brain and the fight, flee and freeze responses. But we also have a rational brain that moderates whether we follow our instinct or 'thwart' it. It is the 'thwarting' that leads to trauma symptoms.

### Trauma as a frozen freeze response

Trauma can result from almost any experience—a fall off a bike at six years old, sexual abuse as a teen, surgery, a car accident or having a death in the family. Trauma is created when a devastating moment is frozen in time. That surge of adrenalin and chemical that was not discharged or let out, stays within us creating havoc. It acts as an 'internal straightjacket,' and interferes with our natural ability to heal by somehow blocking or changing normal reactions to the event. Trauma symptoms are not caused by the event itself, but by our reaction to the event.

For example, if the trauma was a result of a non-life-threatening car accident, a normal reaction after the accident may be to cry, shake and have our muscles turn to 'jello.' But what if, instead, you pretend everything is okay and 'be strong'? What if you jump out of the car, tell everyone you are fine, hold back the tears and carry on to work as normal?

After several weeks or months, you may notice that you have a great deal of anxiety when driving. You may also notice that you are extremely irritable around your family, and you have no desire to work. You feel depressed most of the time, and your neck and back are tense and ache constantly. Somatic Experiencing would consider these symptoms to be signs of unresolved trauma.

### Somatic Experiencing —releasing the body

As a counsellor, my job is to help people get out of the freeze response and discharge the adrenalin and chemicals that are keeping them stuck. SE helps people become resourced (i.e., strong enough) to handle the energy from the unresolved trauma and to allow the energy to be discharged. Without resourcing, there may be retraumatization.

Since trauma is locked and blocked at a body level, we need to free it at a body level. Body? What's that? Most people live in their heads, and are unaware that a body is attached. Somatic Experiencing helps people access information not only at a cognitive level, but also at sensation, behavioural, imaginal and emotional levels.

My training has taught me numerous ways to work on various types of trauma, with both children and adults. In a typical SE session, I may ask you to track and describe sensations you are experiencing or images that appear as you talk about the subject. These may be indicators of blocked responses or of resources that could help you move forward. You may spend part of the session with your eyes closed, trying to focus inward as we chat and explore how the body has stored the traumatic event. I may ask you to do some 'exercises' to help stimulate various parts of your nervous system, which may be shut down.

I am very excited to have this tool and knowledge—Somatic Experiencing—to share with the people in my community. Often, the result of this way of working is the disappearance of physical or mental symptoms that had no apparent cause previously. Increased joy and liveliness is a frequent result, as people open themselves up again.

**footnote**

1. Levine, P.A. & Frederick, A. (1997). *Waking the tiger: Healing trauma*. Berkeley, CA: North Atlantic Books.

# The Aftermath of Rape

## Cognitive-behavioural treatment for post-traumatic stress disorder

**Debra Kaysen, PhD**

*Debra is an Assistant Professor in Psychiatry and Behavioral Sciences at the University of Washington in Seattle. Her research has focused on PTSD in female victims of interpersonal violence and, specifically, on the relationship between PTSD and alcohol problems*

Women and men, young and old, rich and poor—sexual assault is common and cuts across gender, age, race and socioeconomic status. It is normal and usual to feel a wide variety of emotions after a rape. Survivors may feel very isolated and alone afterwards. They may feel like they can never tell anyone, like they will never heal. But in fact, reactions to rape vary widely from person to person. And many people actually recover on their own, or with the help of family, friends or their faith.

Some people, however, may develop chronic reactions that signal a need for professional help. These reactions can include feeling like they are reliving the rape, having nightmares about it, trying not to think about it or remember it, avoiding things that may make them think about it, feeling cut off from their feelings or relationships, feeling jumpy or on guard, having problems sleeping or concentrating, and feeling depressed or down.

Some survivors may have been experiencing psychological troubles before the rape, which may make recovery more difficult. Survivors may try to manage their reactions by using alcohol or drugs. Alcohol or drugs might work momentarily to improve symptoms,

**footnotes**

visit www.heretohelp.bc.ca/publications/visions for Debra's complete footnotes or contact us by phone, fax or e-mail (see page 3).

but do not work well over time, leading to possible substance dependence on top of the other reactions.

## The cognitive-behavioural treatment option

Post-traumatic stress disorder (PTSD) is the most common diagnosis associated with rape. The good news is that there are a number of treatments that have been developed for PTSD. There are both medications and several psychotherapies (talk therapies) that researchers have found treat PTSD well.[1] The focus of this article is on cognitive-behavioural therapy (CBT).

CBT has been found across a variety of research studies to effectively treat PTSD symptoms.[2-3] This therapy is generally focused and short term, and includes learning new skills. It may involve practicing new skills between sessions. It will often include teaching clients and their families about how people get PTSD and how treatment is likely to help them get better.

Treatment may involve exposure.[4] This can include exposure to memories of the event and exposure to safe reminders of the event. Both of these parts of treatment allow the survivor to re-experience reminders of the event in a safe place. They also allow survivors to look at their reactions and beliefs about the rape. This allows survivors to resolve strong feelings, like shame, fear, anger, guilt or disgust that are common for rape victims. The other goal for exposure treatments is to teach survivors how to cope with their reactions to the rape without getting overwhelmed or avoiding.

Therapy may also work directly on thoughts or beliefs about the rape. This has also been found to be helpful.[5] Beliefs may have been shaped by the rape in a way that is either inaccurate or unhelpful. Survivors are taught skills to find these unhelpful beliefs, test them and change them if they are not working. The idea is that by changing beliefs you can change emotions and behaviours too.

Therapy might also include learning: breathing skills or biofeedback to reduce anxiety, new ways to manage or reduce anger, coping skills for future trauma reactions, and ways to communicate more effectively with people.

Both exposure-based and cognitive therapies have been found to be generally safe and effective and appear to have lasting benefits.[6-8] These therapies can be conducted individually with a therapist or in a group setting. To benefit from these therapies, survivors need to be able to step forward and ask for help. And, they have to be willing to talk about the rape with the therapist. Even now, rape is a vastly under-reported crime.

## Impact of alcohol and drugs on PTSD treatments

PTSD together with substance use can be a particularly difficult combination for survivors and treatment providers to address. PTSD symptoms may make it more difficult for survivors to finish substance abuse treatment and to remain clean and sober. At the same time, substance abuse may make it harder for survivors to finish PTSD treatment. Also, many therapists will not offer cognitive-behavioural therapy for PTSD to someone who is currently substance dependent, because of concerns about treatment drop-out or making someone's substance use worse.

A number of researchers and clinicians believe that treating both the PTSD and substance dependence at the same time is the best option.[9-11] Several combined CBT treatments have been created that teach people ways of coping without using alcohol or drugs and also help treat PTSD symptoms. Another option that some people choose is to have separate PTSD and substance abuse/dependence treatment providers. Both PTSD and substance use are then treated at the same time, but by experts in each treatment area.

## In summary

It is not uncommon for rape survivors to give up hope that their post-rape reactions can improve. They can get better, however. Some people may need to seek additional help or resources. Treatments exist for PTSD and for substance dependence that work. CBT treatments are the ones we know the most about how well they work. The first step toward recovery may be picking up the phone.

# Post-Traumatic Stress in the Workplace

**Hans Beihl, PhD**

*Hans provides psychological consultation for WorkSafeBC. The views expressed in this article are those of the author and do not reflect the official policies of WorkSafeBC*

In 2005 there were over 164,000 workplace injuries reported in our province. Most workplace accidents involve physical injuries ranging from minor back strains to more serious injuries such as loss of limbs or paralysis.

Coping with the adverse effects of an injury can be stressful, but most workers manage to adjust without serious difficulties. Sometimes, however, when a worker's life is threatened or placed in serious danger, the person can become emotionally traumatized. That is, the person becomes overwhelmed by anxiety and stress and has great difficulty coping with even ordinary daily tasks.

## Joe

Consider, for example, Joe, a healthy 47-year-old worker, who was installing windows in a high-rise when the scaffold collapsed and he fell to the ground 15 feet below. Joe suffered a neck injury and fractures to both his legs. At the time of the accident he thought he would die. He slowly recovered from his physical injuries, but remained highly fearful of

working at heights. He had frequent dreams of falling and would wake up in a sweat. Even weeks later he often replayed the accident over in his mind as if it had happened yesterday. When he saw others climbing ladders, his anxiety would shoot up and his knees buckle. Joe worried that he would never be able to return to his job.

### Mary

While most work accidents involve physical injuries, some do not. Mary, a single mother with two children, was working as a teller in a bank, when two masked men armed with guns stormed in. Everyone was ordered to lie down on the floor. One of the robbers kicked Mary and told her he would kill her if she moved. Mary was so frightened she lost control of her bladder. For hours after the robbery, she shook uncontrollably.

Before the robbery, Mary's world had looked safe and predictable, but now she was afraid to leave her home on her own. She feared that someone would come up behind her and attack her. Even when her friends accompanied her to public places, she felt nervous and was constantly on the lookout for danger. At night, Mary often woke up in panic, thinking she had heard someone breaking into her home. She lost interest in everything and began to drink more heavily to numb her feelings.

### Traumatic events and risk factors

Both Joe's and Mary's anxiety symptoms were diagnosed as post-traumatic stress disorder (PTSD). Their anxiety symptoms were controlling their lives, and they felt helpless to change their situation on their own.

In BC last year, there were over 100 work injuries resulting in PTSD. Assaults in the workplace, loss of fingers or limbs, falls and serious motor vehicle accidents are some of the types of accidents that can result in emotional trauma. Individuals who have a pre-injury history of sexual assault, problems with depression or anxiety or with alcohol and drug abuse, or prior exposure to emotional or physical abuse, are more at risk of becoming emotionally traumatized.

### Cognitive-behavioural therapy

Sometimes the anxiety symptoms that develop following a workplace accident resolve over time. In more severe cases, however, treatment is required to help the person regain control of his or her life.

Cognitive-behavioural therapy (CBT)[1] is the most commonly used non-medical approach to treatment of PTSD. This approach focuses on helping the client come to terms with the traumatic event and regain a more realistic perspective of the risks and dangers in the world. A key aspect of this treatment approach involves helping the person face the situations they avoid due to anxiety. This is one of the greatest challenges for the client, since the instinctive reaction is to keep distant from what is feared.

Antidepressant medications are also often used in combination with CBT, or as an alternative treatment approach.

### Recovery

Individuals differ in their ability to tolerate anxiety and face their fears. Most people recover from PTSD within three to six months. In some cases, despite treatment, symptoms may last for years. In one study of 44 people who were emotionally traumatized in the workplace in BC, two thirds were able to return to work by 10 months, many returned to the same or a modified job, some workers were placed in a different job, and one third wasn't able to return to work.[2]

Both Mary and Joe, however, with treatment, managed to regain control of their lives and return to work.

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# Violence and Trauma in the Lives of Women with Serious Mental Illness

## A report synopsis

Shanti Hadioetomo

*Shanti is an undergraduate student in communication studies at Simon Fraser University. She is currently on a co-op term at Canadian Mental Health Association, BC Division*

Violence and trauma have serious health impacts for women.

In 2002 the BC Centre of Excellence for Women's Health (BCCEWH) published a report, *Violence and Trauma in the Lives of Women with Serious Mental Illness: Current Practices in Service Provisions in British Columbia.*[1] The report looked at how services are delivered to women with chronic and persistent mental health problems who are survivors of violence. The research team focused on five different mental health care settings in two BC health regions, using focus groups and interviews. They also surveyed programs across BC.

The report found that mental health programming and planning still doesn't thoroughly attend to the broad psychological and social aspects of mental health, despite a commitment in the 1998 BC Mental Health Plan.[2]

Marina Morrow, the lead investigator on the report, » continued on page 31

# Sex for Stuff
## It's Not a Fair Trade

Heather Miko-Kelly

*Heather is the Youth Projects Coordinator with mindyourmind.ca, an award-winning international website for youth, based in London, ON. Mindyourmind.ca promotes personal coping, positive mental health and reaching out to get help and give help when times are tough*

** passages in italics are excerpts from one young person's story*

*"I didn't and still don't know who to blame, if anyone. I don't know who I'm more disappointed with: the people that took advantage of me, my parents for not being there, other people for not stopping it, or myself for doing it." **

It's not something we like to talk about or even think about, but the reality is that young people in our urban and rural communities are trading sexual acts for 'things'—like a place to stay, a ride somewhere or even a pack of smokes. Most adults have no idea this is happening.

This is called sexual exploitation. Engaging or luring a person under 18 into the sex trade or pornography, with or without their consent, is a criminal act. The exploiter is often in a position of trust or authority and takes advantage of this trust. Too many children and youth are being victimized every day. It is not okay.

### factors increasing a youth's risk for sexual exploitation

- Seeking a sense of identity or belonging
- Using drugs or alcohol
- Having low self-esteem/self-worth
- Surviving past abuse
- Mental health issues
- Homeless or at risk for becoming homeless
- Disconnected relationships with friends/family
- Being gay or lesbian

### WAYS campaign

*"I was 12 years old, trying to get someone to buy me cigarettes at a variety store in a fairly good neighbourhood of our city. I was approached by a middle-aged man with a car seat in the back of his minivan. He had exposed himself to me and propositioned me to watch him masturbate—and in return he would buy me smokes. He was insistent and conniving with his words and behaviour. I didn't feel like I had a choice. I felt sick to my stomach and anxious. I wanted someone to help me, but really wanted smokes too."*

This personal story, submitted by an anonymous youth, and many others similar to it were the reason Western Area Youth Services (WAYS), a youth agency in London, Ontario, initiated a campaign against sexual exploitation.

In January 2006, WAYS received seven months of funding from the Ministry of the Attorney General, Ontario Victim Services Secretariat, to increase awareness and educate people in their community. The agency developed posters, youth booklets and parent brochures, and gave presentations to social service providers, schools and parents.

Groups were conducted with young people from elementary and secondary schools, group homes and community youth groups. The results were astonishing as youth after youth disclosed personal stories of exploitation and abuse. Approximately 300 anonymous youth were asked if they had ever been sexually exploited and 20% answered yes. When asked if they knew someone who had been sexually exploited, 55% answered yes. It's important to realize that many youth don't ever disclose abuse and that having enough trust to confide in someone can take years. These numbers, therefore, could be a major underrepresentation.

### Mindyourmind.ca builds on WAYS

*"I left the group home when I was 16 to pursue my independent 'career' of prostitution and crazy drug addiction. I lived in shelters off and on. I walked the streets and had sex for money and drugs. I dated drug dealers and they 'helped' me with 'leads.' It was out of control. My body was not mine, and I completely disassociated and separated my head from my body."*

Mindyourmind.ca is an international website for youth, by youth. It strives to reach out to youth who are struggling through difficult times. Mindyourmind.ca acknowledges that those being sexually exploited often turn to self-harming behaviours and substance use to reduce the pain and trauma. And they often have suicidal thoughts. The website provides information, resources and tools to help manage stress, crisis and mental health problems.

Mindyourmind.ca, also based in London, saw the positive impact the WAYS awareness campaign was having on the local community and wanted to promote it on a farther-reaching scale. Given their parallel missions, it made good sense for the two organizations to join efforts in increasing awareness about sexual victimization of youth.

In collaboration with WAYS, mindyourmind.ca created an electronic version of the booklet about sexual exploitation, and developed a short online quiz. Having these resources on the website and the posters available as free downloads targets a much broader audience. Mindyourmind.ca reaches over 60 countries worldwide, including China, where a significant number of women and children are trafficked for the purposes of sexual exploitation.

*"For me, it is too late to prevent what happened or* »

*report synopsis* | *continued from page 29*

told *Visions* in a recent interview: "The most consistent message I heard was that violence and trauma are seen as separate from mental illness and substance use, and more holistic forms of mental health care are needed."

## THE REPORT

### Relationship between mental health and trauma

The report discusses several views on the interrelationship of violence, trauma and mental illness.

#### Mental illness as precipitated by abuse

Many practitioners fail to identify violence and trauma symptoms as separate from symptoms of major mental illness; consequently, many victims of trauma enter the mental health system misdiagnosed with mental illness. It is suggested that when practitioners do view trauma symptoms discretely, some diagnoses may be revised to acknowledge PTSD, rather than, or in dual diagnosis with, major mental illness.

There are some practitioners who recognize that abuse in childhood can be an important cause in a number of psychiatric disorders.

#### Mental illness as a risk factor for abuse

Practitioners are more inclined to accept that mental illness is a risk factor for abuse. The risk can be a direct outcome of the woman's illness and/or medication that she takes for her illness. Medication, as well as co-occurring substance use problems, may impair her judgment, making it difficult for her to protect herself from violent attackers and/or coercive sex.

Studies have demonstrated strong links between trauma and later substance abuse, suggesting that women may use substances to self-medicate the psychological symptoms arising from trauma. Not surprisingly, women with histories of repeated abuse are more likely to face homelessness, addiction and mental illness diagnoses, placing them at further risk for sexual and physical abuse. As a result, homelessness, substance abuse and being diagnosed with mental illness are both outcomes of, and risk factors for, future abuse.

#### Victimization in the mental health system

Trauma associated with the mental health care system in British Columbia—that is, the way services and treatment are provided in the province—has been recognized as a serious concern.

Retraumatization may arise from standard treatment practices. For instance, physical and chemical restraints can trigger feelings of powerlessness. Stigma and powerlessness are central to the experiences of trauma and psychiatric hospitalization. Betrayal is another dynamic of abuse. Even when treatment providers act in the 'best interest of individuals, the treatment process may re-create previous patterns of abuse.

## Findings

### The need for gender analysis

That women are more often targets of intimate violence is a fact resulting from gender analysis (i.e., analysis that examines differences in men's and women's lives).

Many mental health professionals, however, downplay the significant role violence and trauma play in women's lives. Or, professionals choose to see it as an issue separate from mental health; consequently, current assessment tools and treatment plans don't regularly take violence and trauma into account. This severely limits the ability of the mental health system to respond effectively to people who have experienced violence and trauma.

### Mandates and diagnoses

Service providers working in hospital settings, as well as those working on community mental health teams, stated that their treatment is driven by policy mandates. Policy directs most of system's resources to people who primarily have Axis I diagnoses,[3] such as mood disorders, anxiety disorders and psychotic disorders.

Many symptoms associated with histories of severe trauma and abuse, however, are consistent with symptoms that result in Axis II diagnoses,[3] such as borderline personality disorder, dissociative identity disorder, eating disorders and post-traumatic stress disorder. An Axis II diagnosis can mean being refused hospital or community mental health services. This means that the practitioners were not able to adequately treat women with Axis II diagnoses. As a result, a screening process may unintentionally affect the ability for violence and trauma survivors to access services, resulting in overuse of emergency services.

### Is addressing violence "counter-therapeutic"?

Trauma specialists suggest that women need sufficient ego strength and support to begin exploring traumatic life events. Thus, bringing up the past is damaging if she is unable to access long-term support. Pragmatically, many workers recognize that without specific programs and supports in place for women, it is not possible to begin addressing trauma histories.

#### footnotes

1. Morrow, M. (2002). *Violence and Trauma in the Lives of Women with Serious Mental Illness: Current Practices in Service Provisions in British Columbia.* Vancouver, BC: BC Centre of Excellence for Women's Health. www.bccewh.bc.ca/PDFs/violencetrauma.pdf.

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3. American Psychiatric Association. (2000). Multiaxial assessment. In *Diagnostic and statistical manual of mental disorders (4th ed., text revision).* Washington, DC: author.

*stuff for sex* | *continued from previous page*

*to lessen the burn, and my experiences will not reap the immediate benefits of this program. However, I feel solace in the fact that for others it may not be as isolating if initiatives like this continue. I will continue to promote and advocate for people who have had so much taken away from them because of other people. This to me is the only bit of empowerment I, personally, can get back."*

**for more info**

contact www.mindyourmind.ca or www.ways.on.ca.

### The need for training and specialized programs

Participating mental health providers identified the need for training that addresses the interconnections between violence, trauma, mental health and substance use. They indicated that they had very little training and education on the topic of violence against women. Programs and opportunities exist, but they are not systematically required for mental health training.

Specialized programs are needed to serve distinct populations of women, such as Aboriginal, immigrant, refugee and incarcerated/imprisoned women.

### Role of women-serving community organizations

Service demands and lack of training in working with women diagnosed with mental illness means that some providers are unable to meet the needs of women with chronic and persistent mental health problems. Some only serve these women if certain conditions are met; e.g., if they are drug and alcohol free. Some workers feel they are being used by an under-resourced mental health system as a solution for women needing more intensive, long-term care.

### Innovative Practice and Programming

More women-only services, peer support programs, violence-specific mental health programs, and gendered policy initiatives in mental health are recommended.

### A few final words from the researcher

What, to Morrow, was the most surprising discovery in this research? "Despite the evidence base of the impact of violence and abuse on mental health, as well as in the lives of people with mental illness, the mental health field has resisted developing programs and supports for this population," says Morrow.

There is, however, some evidence of emerging sensitivity in mental health to the needs of women survivors of violence and trauma. The report describes a number of innovative programs and practices. Several initiatives address mental health practitioner training, and there is some recognition that violence against women is a serious concern on a policy level.

What is lacking, however, is a clear commitment to thoroughly addressing the impact of violence and trauma on the mental health of women with chronic and persistent mental health problems.

Morrow urges: "Get informed about the issue. Learn about the work being done in the anti-violence/women's service sector to develop programs that address violence, mental health and addictions."

# VictimLINK

Shanti Hadioetomo and Hazel Smith

*Shanti is an undergraduate student in communication studies at Simon Fraser University. She is currently on a co-op term at Canadian Mental Health Association BC Division*

*Hazel is Coordinator of Communications and Marketing at Information Services Vancouver*

*A VictimLINK staffer was interviewed for this article. She is a Certified Information and Referral Specialist and a Registered Clinical Counsellor, who has volunteered as a victim services worker with the Vancouver Police Department*

VictimLINK is a 24-hour, seven-day-a-week free telephone helpline for victims of family and sexual violence, and all other crimes. Certified information and referral (I&R) specialists refer VictimLINK callers—more than 11,000 in 2005–2006—to a network of social, health, justice and government resources.

Operated by Information Services Vancouver (ISV) and funded by the Ministry of Public Safety and Solicitor General, VictimLINK can provide service in 130 languages, courtesy of multilingual staff and a professional interpretation service.

Serving British Columbians since 2003—and Yukoners since 2004—VictimLINK replaced the former weekday Victims Information Line, which ISV had operated since 1987. "This revamped service also serves victims of all types of crimes, but places more emphasis on the help we can give to victims of family and sexual violence. It's also available around the clock now," explains the ISV staffer. Since the enhanced service was launched, call volume has increased by 30%.

### What do people call about?

The majority of inquiries involve specific criminal offences. Spousal assaults, sexual and non-sexual assaults, child abuse, elder abuse and criminal harassment are most common. Less frequently mentioned offences include abduction, arson, fraud and homicide.

Since VictimLINK started, however, staff have seen an increase in the number of calls relating to non-Criminal Code issues. "Prior to VictimLINK, most of the calls were related to crimes like assault, abuse, theft and so on. Now we also get more calls about human rights violations, and from people who feel they've been discriminated against or treated unfairly. So, victimization is seen much more broadly." This is believed to be largely due to effective promotion.

### Who calls?

People of all ages, ethnicities and walks of life contact VictimLINK.

Usually, the person who has been victimized makes the call, but there is a small percentage of calls—16% in 2005–2006—from 'third party' callers, frequently a family member or friend. This is common in spousal assault cases. In this type of situation, staff might encourage the concerned individual to maintain contact with the woman who is being abused. "This is very important and useful to the

woman, because her situation becomes more dangerous the more isolated she becomes."

Some people seek help immediately following an incident, while others wait. "We might get a call from a parent who's concerned about an incident that happened to their child some time back; it's taken six months for the parent to start putting the pieces together. On the other hand, with sexual abuse, we're talking both historical and current. A recent incident can trigger the caller to request counselling as a result of past or ongoing sexual abuse."

People with mental illness or addiction issues are more often victims of crime. And, victimization can result in mental health problems due to the trauma of the injury, violation or abuse. As a result, VictimLINK staff often respond to people who are psychologically and emotionally fragile. They also receive calls from people with diagnosed mental health disorders, who are suffering symptoms like paranoia, psychosis or dissociation. Often, these individuals already have a mental health worker assisting them. Although VictimLINK staff don't deal directly with the caller's mental health and/or addiction issues, they do identify the services best able to meet the individual's particular needs and encourage them to seek help. People who feel victimized by the system because of their disorder are referred to advocacy groups and legal resources.

Crisis calls represent only a very small percentage (2%) of VictimLINK's annual total inquiries.

**Who answers the calls?**

VictimLINK staff come mostly from social work and psychology backgrounds, and have worked in a variety of social service settings. They are trained in-house through a comprehensive program that includes specialized training in such areas as sexual offenders, youth gangs, and gay, bisexual, lesbian and transgender (GBLT) issues.

Because staff are trained to respond to calls on all ISV helplines, which includes the Alcohol and Drug Information and Referral Line, they are very comfortable dealing with cross-over issues that arise. For example, a VictimLINK caller who has been assaulted might also have a drug addiction.

Every call is different, but generally the staff's objectives when responding are to listen, to diffuse any crisis feelings, to have the caller identify resources (perhaps a family member or friend) they can call upon for support, and to have the caller prioritize their concerns so they can focus on one issue at a time. Staff may discuss the option, and possible outcomes, of reporting a crime incident to the police. If necessary, callers who are in a crisis situation can be directly transferred to immediate outside help.

And, the I&R specialists detail the resources that are available to a caller. "We have a very comprehensive database of resources to draw on, so wherever the caller lives, and whatever their concerns, we can refer them to a variety of resources."

Some of the most frequent referrals are to community-based victim services, police-based victim services, counselling agencies, the Crime Victim Assistance Program and transition houses. Other referrals include mental health teams or units, addiction counselling, specialized counselling, support groups, advocacy groups, the Ombudsman and women's centres. I&R specialists also provide information on the justice system, relevant laws and programs, crime prevention, safety planning, protection orders and other resources as needed.

"Most important, though," says the ISV staffer, "is to listen and to let the person know that one-on-one help is available."

**VictimLINK**

Available 24 hours, seven days a week
BC toll-free:
**1-800-563-0808**

Deaf or hard-of-hearing callers:
TTY 604-875-0885 (collect calls accepted) or Text 604-836-6381

# Police Victim Services

## Overseeing Frontline Response

Carolyn Sinclair

*Carolyn is Executive Director of Police Victim Services of British Columbia*

Police Victim Services of British Columbia is a non-profit association that enhances services to victims of crime and trauma by assisting and supporting frontline, police-based victim services programs. Our members include victim services program managers, staff and volunteers who work within police agencies or detachments throughout BC.

Victim services units are made up of staff and volunteers who have completed or are undergoing intense basic and advanced training. Academic certification has been newly launched by the Ministry of Public Safety and Solicitor General, Victim Services Division, in partnership with the Justice Institute of BC. Some training is conducted in-house by individual programs. Coordinators and managers receive advanced training, sponsored by the Victim Services division of the Minis-

try of Public Safety and Solicitor General, and delivered by industry experts and specialists. Police Victims Services of BC also hosts an annual training symposium, which provides two days of training and networking opportunities for staff and volunteers.

Police victim service programs respond to police incidents where there is a victim of crime or trauma. A few examples of services provided include: responding to motor vehicle accidents to provide support or transportation; assisting police officers in a sudden death situation, by delivering next of kin notifications; or offering support and follow-up to victims of home invasions, robberies or assaults. The frequency and severity of the calls responded to vary from minor to extreme.

Police victim services are primarily "crisis response." Victim service workers are not trained in formal counselling; rather, they provide prompt, short-term intervention. They assess victims' needs, refer them to services and community resources that may benefit or assist the victim or their family, and provide follow-up. Emotional support is provided—in person, and/or over the phone.

Victim services workers may assist the general public by managing files involving multiple victims of homicide or domestic violence. They help victims prepare victim impact statements, apply for compensation if eligible and keep current on the court process. Advising victims when offenders are released and the conditions of their release is critical information for effective safety planning for some victims.

### Victim services support

Victims and witnesses of a crime are entitled to victims services support. Following a criminal incident, a police officer or case worker is responsible for ensuring that victim support service has been offered. When dealing with youth, the officer or case worker must get parental or guardian consent in order to provide the services to a youth.

Once the service has been offered and the victim has accepted, a victim services staff member or trained volunteer is assigned. Victims' immediate needs are assessed as soon possible following a crime. Victim services engage with the client once the victim's health and well-being are addressed and statements secured by the police. Discussion between the victim, police member, health care professionals and/ or a case worker from a specialized agency will establish the priorities, resources and services to best meet the client's needs. This can take place minutes, hours or days following a crime.

Based on the needs assessment, the victim support worker connects with the appropriate professionals, to ensure the victim's needs are met. For instance, in circumstances where a victim has needs related to mental health, a professional in that field would be contacted, a referral made and a case worker assigned. This can be done during regular hours by calling direct, or by utilizing "after-hour" contacts, who respond to incidents occurring outside regular business hours.

Service providers work together to develop a response plan—this may include emotional support, personal safety planning, court information, transportation, assistance and treatment. A collective approach and an effective referral system enable short- and long-term planning for clients. Resource contact information in the form of lists, directories and personal notebooks is usually kept near at hand.

Knowing what specialized community and health care programs are available, and fostering relationships with other service providers, is one of the best ways to meet the needs of victims of crime and trauma. Victim services and service agencies work together to promote one another's strengths, bridge gaps where services may be lacking, and strategize customized plans for access and delivery of services. Ongoing communication ensures current knowledge of the resources available in the community.

# Complex Interactions

## Women, Trauma, Addictions and Mental Health

**Susan Armstrong, MEd, RCC**

*Susan works in Vancouver as a Program Manager for the BC Association of Specialized Victim Assistance and Counselling Programs. Previously she provided trauma counselling in Toronto and Vernon, BC*

Counsellors who work with survivors of violence are aware that many of their clients have issues of addiction and mental health. The relationship of trauma to addiction and mental health is complex and, to date, inadequately researched.

Research has documented that mentally ill people are highly vulnerable to violence. One study revealed that people with a mental illness are 2.5 times more likely to be a victim of crime,[1] and another study documented that 81 % of psychiatric inpatients had experienced serious physical and/or sexual assault.[2] Other studies reveal that women, in particular, use alcohol and drugs as ways of managing trauma related symptoms.[3]

As a Stopping the Violence counsellor and as a therapist specializing in trauma, I found that many of my female clients with addictions or mental health diagnoses had significant histories of childhood abuse and neglect and experiences of assault in adulthood.

The following client stories show the complex interactions of trauma, mental health diagnoses and alcohol and drug use.

## Sylvia

Sylvia* was a participant in a re-employment program for women. She was referred for counselling because she frequently zoned out in classes and was unable to remember much of what had occurred in the day. Sylvia had a long history of heroin addiction and was on methadone. The program facilitator wanted to know whether her attention difficulties were due to the methadone.

After establishing rapport with Sylvia, I conducted a dissociation assessment. This revealed that she experienced various forms of dissociation on a consistent basis.

When asked about her life, Sylvia related how she had become hooked on drugs during a relationship with a man involved in the drug trade. She had engaged in drug use and trade to keep herself safer with her abusive boyfriend: if Sylvia got high with him and complied with his demands that she traffic drugs, she was beaten less often. Sylvia eventually ended up on the streets. She went through drug treatment a number of times before managing to leave the streets and the city permanently and be placed on methadone.

In the years that Sylvia was in and out of drug treatment, no one had ever asked her about childhood experiences of assault and neglect. Nor had anyone adequately understood her level of terror regarding her ex-boyfriend and his association with a gang.

Sylvia's story illustrates how drug use can be a survival strategy within abusive relationships. The drug use helps distance a survivor from feelings of terror.

## Karen

Karen is a 20-year consumer of mental health services. She was referred to counselling at age 37 by her psychiatrist. Her psychiatrist was aware that Karen had a history of childhood sexual abuse, but this had been left unexplored. She had been treated solely with medications and/or electric shock therapy.

Karen remained in counselling for her childhood sexual abuse for years. She did recover her sense of safety and ultimately triumphed over her suicidal and self-harming behaviours.

Several years into her counselling process, I asked Karen what her psychiatric diagnosis was. Laughing, she asked me which one. She had had nine diagnoses over the years. Her psychiatrist was now considering post-traumatic stress disorder as a primary diagnosis.

Although Karen is mentally ill and remains on medication, her self-esteem and self-love are restored, she's engaged in her community and she's able to have trusting relationships. But I often wondered what Karen's life could have been if her trauma history had been assessed and a referral to counselling made when she had her first psychiatric admission at 17.

## Alita

Alita was referred for counselling by a public health nurse after having an episode of rage during a home visit. Alita had overcome a severe addiction to alcohol and had maintained sobriety for years. She was, however, a regular consumer of marijuana and felt great shame about her use.

Alita's trauma history was profound. Her childhood was filled with severe neglect, assault and rape, and her adult life with serious physical and sexual assault and ongoing poverty and racism. As she worked through her trauma history—both historical and current—Alita's isolation decreased, and her self-esteem and parenting improved.

Although Alita was able to reduce her marijuana usage, she was unsuccessful in abstaining completely. Attempts to do so resulted in immobilizing depression and rage—symptoms that were not successfully managed by antidepressants. It became clear that marijuana was medicating Alita against some of her strongest trauma-related feelings.

These three case examples of courageous, resilient survivors of trauma illustrate the complex intersection of trauma, addiction and mental health. It is important to assess whether an addicted or mentally ill woman has a trauma history. Assisting women to safely containing their trauma-based symptoms while slowly working through their experiences can truly transform lives.

Other studies reveal that **women**, in particular, use alcohol and drugs as ways of **managing** trauma related symptoms.[3]

*All names and some details have been changed to protect client confidentiality.*

### bc association of specialized victim assistance and counselling programs

- BCASVAP coordinates initiatives for and supports programs across BC including community-based victim assistance, Stopping the Violence counselling programs and sexual assault centres
- the organization provides a voice for community based service providers and for those who have been victimized by violence.
- to find anti-violence support near you, call 604-633-2506 or visit the online services directory at **www.endingviolence.org**


**footnotes**

1. Hiday, V.A., Swartz, M., Swanson, J. et al. (1999). *Criminal victimization of persons with severe mental illness.* Psychiatric Services, 50(1), 62-68.

2. Jacobson, A. & Richardson, B. (1987). *Assault experiences of 100 psychiatric inpatients: Evidence of the need for routine inquiry.* American Journal of Psychiatry, 144(7), 908-913.

3. Davis, R.E., Mill, J.E. & Roper, J.M. (1997). *Trauma and addiction experiences of African American women.* Western Journal of Nursing Research, 19(4), 442-460.


## Support organizations

- VictimLINK: 1-800-563-0808 (available 24/7) or e-mail them via the form at www.vcn.bc.ca/isv/victims.htm
- BC Association of Specialized Victims Assistance and Counselling Programs: www.endingviolence.org
- Police Victim Services of BC: www.policevictimservices.bc.ca
- Griefworks BC: www.griefworksbc.com
- Anxiety Disorders Association of BC: anxietybc.com or 604-681-3400
- Anxiety Disorders Association of Canada: www.anxietycanada.ca
- Mental Health Information Line: 1-800-661-2121 or visit our online message board at www.heretohelp.bc.ca
- BC Institute Against Family Violence: www.bcifv.org or 1-877-755-7055

*this list is not comprehensive and does not imply endorsement of resources*

*don't forget all the resources listed at the end of Visions articles as well*

## Research and networks

- Canadian Traumatic Stress Network: www.ctsn-rcst.ca
- International Society for Traumatic Stress Studies: www.istss.org
- National Center for Trauma-informed Care (US): mentalhealth.samhsa.gov/nctic
- Australian Centre for Posttraumatic Mental Health: www.acpmh.unimelb.edu.au
- The Adverse Childhood Experiences (ACE) Study: The Effects of Adverse Childhood Experiences on Adult Health and Well Being, Kaiser Permanente & US Centers for Disease Control and Prevention: acestudy.org
- Statistics Canada. (2007). Impacts and consequences of victimization, General Social Survey 2004. Includes mental health impacts. www.statcan.ca/english/freepub/85-002-XIE/85-002-XIE2007001.htm
- Serving the needs of women with co-occurring disorders and a history of trauma. (2005). [Special issue]. *Journal of Community Psychology, 33*(4).
- The psychological impact of trauma: Theory, research, assessment, and intervention. (2004). [Special issue]. *Psychotherapy: Theory, Research, Practice, Training, 41*(4).
- Traumatic exposure and PTSD in older adults. (2002). [Special issue] *Journal of Clinical Geropsychology, 8*(3).

## Publications and tools

- BC Partners for Mental Health and Addictions Information. (2006). Child sexual abuse: A mental health issue. *The Primer Fact Sheets on Mental Health and Substance Use Issues.* www.heretohelp.bc.ca/publications/factsheets. Also see our fact sheets on Post-Traumatic Stress Disorder and on Violence
- Morrow, M. (2002). Violence and trauma in the lives of women with serious mental illness: Current practices in service provision in British Columbia. BC Centre for Excellence in Women's Health. www.bccewh.bc.ca/PDFs/violencetrauma.pdf
- Canadian Resource Centre for Victims of Crime: crcvc.ca
- National Center for PTSD, US Department of Veterans Affairs: www.ncptsd.org. Check out the PTSD Information Center and the Psychological First Aid Manual for Mental Health Care Providers
- Everett, B. & Gallop, R. (2000). The link between childhood trauma and mental illness: Effective intervention for mental health practitioners. Sage.
- Office for Victims of Crime (US). Victim empowerment: Bridging the systems—Mental health and victim service providers (2000) and First response to victims of crime who have a disability (2002). www.ojp.usdoj.gov/ovc/publications
- Disaster Mental Health Institute, University of South Dakota: www.usd.edu/dmhi. Publications look at the aftermath of a disaster, witnessing a disaster and how to help children cope.
- Coping with Traumatic Events website, US Substance Abuse and Mental Health Services Administration: mentalhealth.samhsa.gov/cmhs/traumaticevents
- Health Canada. (2004). Preparing for and responding to workplace trauma: A manager's handbook. www.hc-sc.gc.ca/ewh-semt/pubs/occup-travail/empl/trauma/man_hand-livret_gest/index_e.html



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