

crosscurrents

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The Journal of Addiction and Mental Health



Are you trauma-informed?

NO SAFE HAVEN

Restraints reform
targets traumatizing
hospital practices

"HEAR ME, DON'T HURT ME"

Lessons in trauma
and transformation

FAMILY MATTERS

Can we provide
trauma-informed
family-centred care?

TRAUMA ON THE WARD

Is gender segregation
the answer?

It's not just horsing around Harnessing the power of equine therapy

"Get over it!" Combating myths about PTSD



Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

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A trauma-informed checklist

Haunted, Eva-Marie Stern, pencil, crayon and watercolour, 8.5" x 11"

Eva-Marie is an art psychotherapist with the Trauma Therapy Program at Women's College Hospital in Toronto. "I can always see my traumatic experiences in my art. It's hard to imagine life without art-making to re-view it all again and again, changing how I see myself and what I've experienced every time I make a new image."



Every day, front-line mental health and addiction professionals work with people who have a history of trauma – physical, sexual or emotional abuse, witnessing violence, disaster or war. These front-line professionals are often the first to hear about a client's trauma history, yet most feel unprepared to deal with trauma issues. While few people in treatment initially identify trauma as their main issue, it is clear that traumatic experiences and their aftermath are closely interwoven with mental health and addiction problems.

This doesn't mean that every front-line professional must do trauma therapy. Rather, it means that these practitioners and the organizations for which they work must acknowledge the prevalence and pervasive impact of trauma on the lives of people with mental health and addiction problems. At the service level, it is not so much *what* front-line professionals do to help, but *how* they do it. Trauma-informed care, as one trauma survivor put it, means asking not

“What is wrong with you?” but “What happened to you?”

Tim Wall, director of Counselling Services at Klinik Community Health Centre in Winnipeg, Manitoba, describes a province-wide initiative that has led to the development of a trauma-informed care toolkit, which includes the practical checklists reprinted in this issue. Anne Ptasznik's story about restraints reform challenges inpatient practices that can be retraumatizing for people with histories of trauma – and traumatizing for those without such histories. Other stories discuss client and family involvement in developing and maintaining trauma-informed systems of care. In the Last Word, Dr. Kathy Hegadoren, a professor in the Faculty of Nursing at the University of Alberta, challenges us to consider the implications of same-sex general psychiatry inpatient units.

It is with this issue that David Goldbloom wraps up his tenure as executive editor. I would like to thank him for his



wisdom, creativity, humour and support. In his View from CAMH, David introduces his successor, Dr. Kwame McKenzie, who I know will inspire and challenge *CrossCurrents* to grow in new directions.

Hema Zbogar
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a view from CAMH

This issue of *CrossCurrents* focuses on trauma-informed care, which in its broadest conceptualization means an effort to understand and integrate the experiences of the individual into efforts to support and help that person – a position against which it would be difficult to argue. This is not the same as earlier versions of thinking about trauma, which at its most extreme assumed that everyone with psychiatric symptoms must have been traumatized in some way – a vogue that at its worst led to the transient epidemic of “recovered memories” of satanic ritual abuse a couple of decades ago. Thinking about how traumatic experiences may influence perception of a therapeutic environment and interaction reflects a more nuanced and more client-centred approach.

With this issue, I conclude my tenure as executive editor of *CrossCurrents*. Over the past five years, working with editor Hema Zbogar and

the editorial board has been stimulating and fun, and I am extremely grateful to everyone who has contributed to the content – including our intrepid reporters. It's impossible to conceive of *CrossCurrents* without Hema's drive, intellectual curiosity, willingness to ask tough questions and candour.

The good news is that my successor as executive editor is my friend and colleague Dr. Kwame McKenzie. CAMH was fortunate to recruit Kwame almost two years ago from the Institute of Psychiatry in London, England, where he had already garnered an international reputation as a scholar and communicator – with a background not only as a research scientist but also as a journalist, book author and radio broadcaster. It's the perfect combination of science, advocacy and outreach for *CrossCurrents*. At CAMH, Kwame is deputy clinical director of the Schizophrenia Program

and a senior scientist in the Social Equity and Health research program, as well as medical director for Diversity. He is also a professor of psychiatry at the University of Toronto and a professor at the Institute of Philosophy, Diversity and Mental Health at the University of Lancashire in England. As an academic, he works on the science of improving mental health services, with a particular but broad focus on the social determinants of health. I am confident he will take *CrossCurrents* in new directions and I look forward to joining all of you as an avid reader of upcoming issues!

David S. Goldbloom, MD, FRCPC

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When helping hurts: Program targets vicarious trauma

HELEN BUTTERY

It was the early 80s. Lorraine Telford was a young nurse – empathetic, ambitious and optimistic. Her first job was with a bereavement program in Alberta, which involved visiting grieving family members. Assigned to visit a widow who had recently lost her husband, Telford was shocked to hear that he had died by suicide. “It was horrific, traumatic, painful,” recalls Telford. When she left the woman’s house she felt scared, and the fear stayed with her for several days. At the time, she didn’t know what to call these overwhelming emotions or where to turn for help.

More than 20 years later, Telford discovered that these overwhelming feelings have a name: vicarious trauma (VT). Toronto Public Health (TPH), where Telford works as a quality assurance manager, is developing various VT initiatives so staff won’t have to endure the uncertainty and anguish Telford felt.

During a mandatory one-day workshop, staff learn that vicarious trauma, also known as secondary trauma, is an occupational hazard for anyone working with people dealing with trauma. It results from repeated exposure to client’s horrible stories and the empathetic response they elicit.

Sadly, exposure to trauma is a common experience for TPH staff who work with high-risk families and children. A 2006 employee survey of more than 200 staff confirmed higher than average rates of vicarious trauma among these professionals. That’s not surprising, as staff work with the most vulnerable members of society – children. They are also at a greater risk because they work with clients in extreme poverty and often face situations where a child has been injured or even died.

Few are prepared to deal with the painful stories they hear. Imagine, for example, a dietitian working with a homeless pregnant woman who tells her brutal stories of being raped on the streets. Her professional training certainly did not prepare her to deal with such situations.

To meet this need, the VT workshop educates front-line professionals about vicarious trauma and helps them develop ways to cope. It has been so successful that community agencies from as far away as Thunder Bay in northern Ontario have requested it. The workshop has also been delivered to mental health hospital staff, children’s aid workers and shelter workers throughout Toronto.

Cindy Rose, a mental health nurse consultant for TPH who helped develop and delivers the workshop, says its popularity stems from the pervasiveness of vicarious trauma. “People walk out of the seminar relieved,” she says. “They know something is going on, but they don’t have a name for it.” The relief also comes from understanding that vicarious trauma is not their fault, nor is it a reflection of competency. “We’re not blaming anyone – not the staff, not the client,” says Rose.

Understanding vicarious trauma is the first step towards getting support. To this end, TPH is currently piloting the Peer 2 Peer (P2P) program, which divides staff into teams, with each team headed by a colleague trained in and available to provide peer support. “Co-workers are already providing informal support, but we want to develop a

culture of peer support and recognize its value,” explains Rose. This one-on-one support is essential because people experience vicarious trauma differently. What may not affect one person may trigger vicarious trauma in another. Many factors contribute to a person’s VT threshold, including protective factors, their own trauma and recognizing and addressing signs of strain.

“Unfortunately, professional helpers, especially nurses, are notorious for ignoring their needs,” says Rose. She says that women, who make up the majority of TPH staff, have been socialized to ignore stress alarms that may point to vicarious trauma, such as headaches and stomach problems or feeling grumpy or depressed. Others feel despair and a loss of purpose. When Telford worked at Toronto’s Hospital for Sick Children, she realized that her worldview was changing. She remembers being overly cautious with her daughter because her thoughts about child safety and health were affected by working solely with ill and injured children. She also remembers being depressed. “After being with a dead baby and the family all day, you aren’t able to be as responsive to the joy of your own children when you get home,” she says.

“We need strategies to counter the changes vicarious trauma creates,” says Rose. This could be as simple as exercising or it could include putting positive meaning back into life by contributing to constructive change. Telford, for instance, joined TPH’s VT Committee at its inception in 2005. Still, despite every good intention and effort, vicarious trauma cannot be eradicated. “Empathy is a requirement of the job, but it’s also the vector or root of how trauma is transferred from client to worker,” says Rose. However, with strong supports in place, agencies can help not only clients experiencing the trauma, but also the professionals who work with them. ■

LEARN MORE ABOUT VICARIOUS TRAUMA

The **Headington Institute** provides an online training program about vicarious trauma. Visit www.headington-institute.org, and under Programs, choose “Understanding and Addressing Vicarious Trauma.” The Introduction section links to a reflection questions workbook to help you explore personal and organizational factors in vicarious trauma.

Health Canada’s 2001 *Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers* can be downloaded from the Public Health Agency of Canada web site through a keyword search at www.phac-aspc.gc.ca

The **Infant Mental Health Promotion Project** at the Hospital for Sick Children in Toronto recently published a position paper, “Vicarious Trauma in the Workplace: Supporting Practitioner Effectiveness with Young Children in High Risk Families.” Visit www.sickkids.ca/IMP, and under IMP Resources, choose “IMP documents.”

“Get over it!” Combating myths about PTSD

Throughout history, people have recognized that the experience of extreme stress can have a profound effect on the mind and body; however, it was not until 1980 that the diagnosis of post-traumatic stress disorder (PTSD) was formalized in the *Diagnostic and Statistical Manual of Mental Disorders*. Here we debunk some of the common myths about PTSD.

Myth: Everyone who experiences a traumatic event will develop PTSD.

Fact: PTSD is a human response to markedly abnormal situations, and it involves specific chemical changes in the brain that occur in response to experiencing a traumatic event. However, not all people who experience a traumatic event develop PTSD. This myth emerged from early diagnostic conceptualizations of PTSD. According to the *DSM-III*, “The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone.” In fact, most research suggests that no more than 10 to 20 per cent of trauma survivors experience PTSD symptoms that last beyond one year. A strong support system and resiliency may help trauma survivors; however, even with the best supports, a person may think they are “over” a traumatic event, only to be triggered later and realize they are still emotionally affected by it.

Myth: PTSD is only seen in people with “weak characters” who are unable to cope with difficult situations.

Fact: There is no evidence that PTSD stems from not being “strong enough.” Some risk factors for PTSD include having experienced other traumatic events, having a personal and family history of mental illness and the severity of the trauma.

Myth: All of us have been through frightening experiences and have at least one symptom of PTSD as a result of that experience.

Fact: Although memories of frightening experiences may be similar to symptoms of PTSD (e.g., vivid memories), most people do not have the severity of symptoms or impairment associated with PTSD. The specific brain-based responses seen in PTSD differ from those seen in normal anxiety. Similarly, the experiences of normal anxiety and of PTSD are markedly different.

Myth: Severity of trauma always predicts severity of PTSD.

Fact: By and large, the research literature has not found a relationship between objective trauma severity and extent of psychological distress or severity of PTSD symptoms. Some evidence exists that severity of initial physical injury predicts PTSD in victims of motor vehicle accidents, but this finding has not been consistently replicated. This is likely because the effects of the trauma reflect individual characteristics of the survivor, such as resiliency, and the post-trauma environment, for example, external supports and resources.

Myth: If someone with PTSD tried hard enough, they would be able to move past the traumatic event.

Fact: Perhaps the greatest misconception about PTSD is that the person

is unwilling to move past the traumatic experience and enjoys playing the role of victim when they are angry, scared or unforgiving. Current research is exploring the potential role of the amygdala in holding the “emotional memory” hostage until a safe environment presents itself for expression. This process is not within the control of the individual; rather, it is the brain’s way of protecting the individual until it is safe to express the full impact.

This myth is related to the belief that people will have fewer symptoms of trauma if they just “put it out of their mind.” This belief reflects what psychiatrist and trauma expert Judith Herman has called our culture’s history of “episodic amnesia” about trauma. This myth expresses the wish that trauma will not happen by silencing those who have experienced it.

Myth: People who seem calm and functional at the time of the trauma are “handling” it well.

Fact: This myth reflects mainstream cultural norms that reward non-emotionality and see strong emotions as “hysterics” and “overreaction.” People who are traumatized often experience something called peritraumatic dissociation (PD). People with PD appear calm and functional, but are in fact numb and shut down, acting on automatic pilot. When people have PD at the time of a trauma, they are more likely to experience serious post-traumatic problems later. Trauma is terrifying. Experiencing strong emotions during the trauma and afterwards is a reasonable response to the unreasonableness of horror, betrayal or helplessness, not a sign of weakness or “losing it.”

A “good” trauma survivor is someone like Nelson Mandela or Elie Wiesel – transcendent, articulate and highly functional.

Fact: Often, when people have experienced trauma, it has an impact on their identity and how they understand who they are in the world. Most people do not have transcendent experiences as their immediate response to trauma. It is only well down the path of trauma recovery that people can transform terror and helplessness into spiritual growth or social action.

Myth: Early psychological debriefing of trauma symptoms will prevent PTSD.

Fact: Psychological debriefing of trauma survivors is ubiquitous. However, studies suggest that there is no reliable decrease in PTSD symptoms from such debriefing.

Sources: *Anxiety and Its Disorders* (2nd ed.), edited by D.H. Barlow. New York, Guilford Press, 2002; “Positive change following trauma and adversity: A review.” *Journal of Traumatic Stress*, 2004; “Progress and controversy in the study of posttraumatic stress disorder.” *Annual Review of Psychology*, 2003; “Predictors of posttraumatic stress disorder and symptoms in adults: A meta-analysis.” *Psychological Bulletin*, 2003; *The Complete Guide to Mental Health for Women*, by Lauren Slater et al., Beacon Press, 2003.

Equine therapy harnesses the healing power of horses

KAREN SHENFELD

In his treatise *On Horsemanship*, the ancient Greek historian and soldier Xenophon noted that “horses greatly appreciate” certain “courtesies.” Xenophon, who lived from 430 to 355 B.C., is often cited as the original “horse whisperer.” His prescribed methods for caring, grooming, mounting and training horses for the battlefield and parade ground remain distinguished by their reliance upon gentleness in lieu of the whip and goad.

It has been recognized for more than two millennia that how humans treat horses influences the animals’ behaviour; now researchers are beginning to gather evidence that contact with horses can positively affect humans. “Horses have an intuitive nature and an incredible capacity to mirror who we are,” says professional horsewoman Melanie Gray. “They can help us to change how we react and respond to others.”

Gray founded the Partners in Process Equine Learning Centre (PPELC), a registered non-profit organization situated at Melody Acres, near Owen Sound, Ontario. In August 2008, the Department of Justice granted the organization \$250,000 to run a three-year pilot project, “Connecting Youth in the Justice System with Equine Assisted Illicit Drug Addiction Therapy.”

At the heart of the project is an innovative equine-assisted psychotherapy (EAP) treatment program, aimed at youth 17 and under who have come into conflict with the law because of their substance use. All participants have been referred to the program through the courts, says youth and family counsellor Mark Pratt, who is on staff at the PPELC and works in tandem with Gray.

EAP programs are most often jointly facilitated by a licensed mental health professional and an equine professional, according to the Equine Assisted Growth and Learning Association (EAGALA). The accrediting organization describes EAP as a brief, experiential therapy in which participants learn about themselves and others by participating in activities with horses, and then processing feelings, behaviors and patterns. The focus of EAL is not riding or horsemanship, but on-the-ground activities.

In the pilot program with substance-using youth, Gray and Pratt work together with individual youth once a week, for 12 weeks. Each session lasts between one and one and a half hours and takes place in an indoor riding arena. “In the first session, we place the youth in the arena with two or three horses,” says Gray. “We ask the youth to just observe them. One horse may be standing quietly, and another may be running and bucking. After a while, we ask the youth to choose which horse most represents them and why.”

It’s a revealing process, says Pratt: “They immediately pick a horse and begin talking about their lives, sharing what is going on in their families or what is happening at school. Most of these youth have shut down emotionally as a means of survival. It’s amazing how quickly contact with the horses enables them to open up and get in touch with their feelings.”

Follow-up sessions involve more elaborate activities, designed to help youth build self-esteem, develop trust in others and change their behaviours. “In one of the later sessions, I set out coloured pails around the arena, filled with hay and oats,” Gray

explains. “I then ask the youth to label the pails with the names of the different substances they have been using, and then to keep the horses away from the pails – not an easy task.”

At each session, Pratt sets up a flip chart in one corner of the arena and sits the youth down to discuss and reinforce what they have learned while interacting with the horses. As a counsellor, Pratt uses a wide range of techniques garnered from cognitive-behaviour therapy, solution-focused therapy, strategic family therapy and even Jungian therapy. But Pratt is quick to give credit to the horses for the program’s success. “Many of these kids are wounded and lonely. You can watch them develop a real bond with the animals.”

It’s this unique connection and the promise it holds that lies behind other forms of equine therapy. “EAP is only one of several equine-assisted interventions currently being harnessed by mental health professionals,” says Darlene Chalmers, a social worker on staff at the University of Regina’s Faculty of Social Work. “Equine-assisted learning (EAL), for example, also involves on-the-ground activities with horses to facil-



itate experiential learning, self-awareness, growth, healing and personal transformation, but unlike EAP, this type of program does not involve a licensed psychotherapist.”

In a recent study exploring the benefits of EAL published in *Pimatisiwin, a Journal of Aboriginal and Indigenous Community Health*, Chalmers and her co-authors describe an EAL pilot project that has received federal funding under the National Anti-Drug Strategy to work with First Nations female youth at the residential White Buffalo Youth Inhalant Treatment Centre near Prince Albert, Saskatchewan.

“The EAL project is part of our six-month residential treatment program for First Nations girls between 12 and 17 who are addicted to inhaling volatile solvents,” says executive director Ernie Sauve. The program takes on 10 girls, referred from communities across Canada.

“Our curriculum uses different modalities and is founded upon a First Nations culture-based model of resiliency, as well as a Western health promotion approach,” says Sauve. Holistic in design, the program aims to nurture and renew the “inner spirit,” the “motivator and animator of one’s life,” and to reconnect youth to their kin, community and culture. White Buffalo’s EAL program fits in especially well with the centre’s culture-based treatment curriculum. “In

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“Most of these youth have shut down emotionally as a means of survival. It’s amazing how quickly contact with the horses enables them to open up and get in touch with their feelings”

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Western Cree and other First Nations cultures, the horse is revered as part of the circle of creation,” says Sauve. “It possesses an intrinsic spiritual value.”

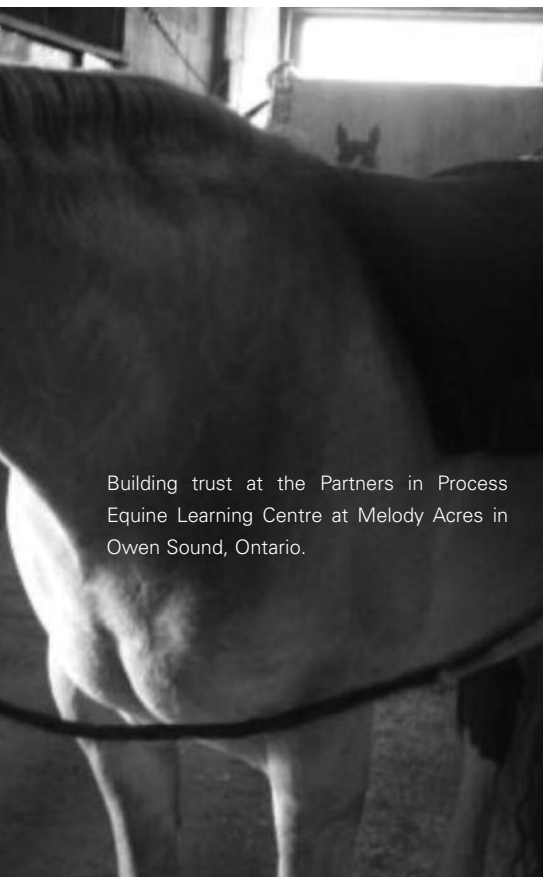
White Buffalo’s EAL program is delivered at the nearby Cartier Equine Learning Center (CELC), a private vocational school certified by the Government of Saskatchewan and the Saskatchewan Horse Federation. The girls are brought to the CELC twice a week to participate in horse-focused, on-the-ground exercises. “Each exercise has been devised to teach a particular life skill, such as the ability to trust, articulate ideas, listen actively, or act with appropriate assertiveness,” says Tamara MacKinnon, CELC’s program director.

The girls work in teams when interacting with the horses. In one exercise, two girls are challenged to lead a horse through an obstacle course. The girls are positioned on either side of the animal, and each girl holds a lead rope, one of which is much shorter than the

other. They are not allowed to step over set boundary lines, and they must also keep both ropes off the ground.

“Many of the girls referred to the White Buffalo Centre have never been exposed to horses,” Sauve says. “Interacting with this new life form revitalizes their sense of connectivity to the natural world.” Many are initially fearful of the animal, but in overcoming this fear, they develop self-confidence and the ability to trust others. As part of their pilot project, White Buffalo and the CELC have joined forces with a diverse team of researchers to gather data to demonstrate, according to accepted scientific standards, that EAL programs are effective.

Sauve is confident in the healing power of horses: “By 2050, First Nations peoples will number 50 per cent of the population of Saskatchewan. Our programs at the White Buffalo Centre are part of an urgent proactive social investment in the health of our future.” ■



Melanie Gray

Building trust at the Partners in Process Equine Learning Centre at Melody Acres in Owen Sound, Ontario.

EQUINE THERAPY RESOURCES

In 1988, the Wyoming Honor Farm (WHF), a minimum-security prison for adult males in Riverton, Wyoming, began a volunteer program in which inmates train wild horses. The horses, culled from herds roaming western U.S. states, must be tamed before they are safe to put up for sale. Under the direction of professional horseman and corrections officer Mike Buchanan, about 25 inmates work in teams to habituate the horses slowly to being ridden. The non-aggressive techniques not only tame the horses; they also help to rehabilitate the men by teaching them the power of patience, gentle persuasion and respect for others.

For other examples of equine-assisted interventions for people with issues ranging from depression to aggression to poor social skills and low self-esteem, check out these web sites:

Cartier Equine Learning Center

www.cartierequinelearningcenter.com

Equine Assisted Growth and Learning Association (EAGALA)

www.eagala.org/informationContent.htm

Canadian Therapeutic Riding Association (canTRA)

www.cantra.ca/EFW.shtml

Partners in Process Equine Learning Centre

www.melodyacres.com



Happiness linked to happiness of one's social contacts

A person's happiness largely depends on the happiness of the people with whom they are connected, according to research from the University of California in San Diego. Using data on 4,739 individuals from the Framingham Heart Study, researchers assessed social networks and measures of happiness over a 20-year period from 1983 to 2003. They found that happy people tended to be connected to one another and that clusters of happy and unhappy people could be observed within the larger social network. Happy people were more likely to be found at the centres of social networks and within large clusters of other happy people. Statistical analysis indicated that clusters of happy people resulted from the spread of happiness, not just from a tendency for happy people to associate with one another. When a person becomes happy, that results in a 25 per cent increase in the likelihood that any of their friends living within a mile will be happy. Similar increases in the likelihood of being happy were seen among co-resident spouses (8%), siblings living within a mile (14%), and next-door neighbours (34%). There was little significant effect on more distant friends and on co-workers. These effects could extend through the social network up to three degrees of separation (e.g., to a friend of a friend of a friend). The authors conclude that their results point to the importance of physical proximity in the spread of happiness and indicate that frequency of social contact is more important than depth of contact.

BMJ, December 4, 2008, doi: 337:a2338, doi:10.1136/bmj.a2338. James M. Fowler and Nicholas A. Christakis, Department of Political Science, University of California, San Diego, California.

Bupropion more likely to benefit some smokers with ADHD

Smokers with the inattention subtype of attention deficit hyperactivity disorder (ADHD) are more likely to benefit from treatment with bupropion than those with the hyperactivity/impulsivity subtype, according to a study from Columbia University Medical Center in New York City. Researchers recruited 583 adults who smoked at least 10 cigarettes a day and gave them eight weeks of treatment with bupropion and the nicotine patch. Of the participants, 540 did not have ADHD, while 20 had ADHD-inattention and 23 had ADHD-hyperactivity/impulsivity with or without inattention. At the end of treatment, abstinence rates for ADHD-inattention smokers were almost identical to those for smokers without ADHD (55% and 54%, respectively). ADHD-hyperactivity/impulsivity smokers had lower abstinence rates than the other two groups. The superior response of ADHD-inattention smokers probably reflects the fact that both nicotine and bupropion improve attention by boosting epinephrine and dopamine levels. Also, because ADHD-inattention smokers were more likely to have experienced major depression, they may have benefited from bupropion's antidepressant properties. The authors conclude that their findings support the idea that the two ADHD subtypes "represent distinct processes and could require specific treatment approaches."

Nicotine and Tobacco Research, December 2008, v. 10: 1717–1725. Lirio S. Covey et al., New York State Psychiatric Institute, Columbia University Medical Center, New York, New York.

Bereavement may be closer to major depression than believed

Bereavement does not meet current DSM criteria for a diagnosis of major depression; however, research from the Virginia Commonwealth University Medical School in Richmond, Virginia, indicates that there is little difference between bereavement-related depression and major depression related to other stressful life events. Using a large sample of twins from the Virginia Twin Study of Psychiatric and Substance Use Disorders, researchers identified and interviewed 82 individuals with bereavement-related depression and 224 with depression related to other stressful life events. The two groups did not differ in duration of their depressive episode or in the number of previous episodes. They also did not differ in rates of depressed mood, weight loss, appetite changes, sleep disturbances, psychomotor changes, or difficulty concentrating. However, those with bereavement-related depression exhibited significantly higher rates of loss of interest and fatigue, but lower rates of guilt. Individuals with bereavement-related depression were less likely to seek treatment. The authors assert that bereavement-related depression can cause significant impairment and does respond to treatment. They insist that the similarities between bereavement-related depression and major depression related to other stressful life events "far outweigh their differences," and that their results make a case for dropping the "bereavement exclusion rule" from DSM-V.

American Journal of Psychiatry, November 2008, v. 165: 1449–1455. Kenneth S. Kendler et al., Virginia Institute for Psychiatric and Behavioral Genetics, Virginia Commonwealth University Medical School, Richmond, Virginia.



Acetaldehyde links binge drinking with cardiovascular disease

Research has demonstrated that binge drinking can contribute to atherosclerosis, characterized by hardening of arteries and the build-up of fatty deposits within them. A new study from the University of Rochester Medical Center in New York, has begun to uncover the mechanism by which binge drinking leads to the disease. Researchers treated endothelial cells (cells that line blood vessel walls) and monocytes (types of white blood cells) with acetaldehyde for six hours. The ethanol in alcoholic beverages is converted into acetaldehyde and blood levels of acetaldehyde are known to be high following binge drinking. When researchers administered acetaldehyde at levels comparable to those found in binge drinking, the result was a 700 per cent increase in adhesion of monocytes to endothelial cells, which causes inflammation and blockage of the blood vessels. Acetaldehyde also increased the expression of the receptor CCR2 (chemokine [C-C motif] receptor 2) in monocytes and of the proteins P-selectin and TNF α (tumor necrosis factor alpha) in endothelial cells, all of which stimulate adhesion of monocytes to endothelial cells. The authors argue that following alcohol consumption, "there is a delicate equilibrium between the effects of ethanol [alcohol] and its metabolite, acetaldehyde, on the vasculature." Further research is required to determine whether these results, based on cell cultures, can be replicated in living people, and whether the effects of acetaldehyde provide a mechanism underlying the connection between binge drinking and cardiovascular disease.

Atherosclerosis, 2008, doi:10.1016/j.atherosclerosis.2008.10.008. Eileen M. Redmond et al., Department of Surgery, University of Rochester Medical Center, Rochester, New York.

Much of risk for PTSD, anxiety and depression inherited

A new study of survivors of a catastrophic earthquake that struck Armenia in 1988 demonstrates that a substantial proportion of the risk for post-traumatic stress disorder (PTSD), anxiety, and depression is inherited. Researchers from the University of California in Los Angeles studied 200 individuals from 12 multi-generational families in the town of Gumri who were exposed to the earthquake. Participants were assessed for their objective experience of the earthquake, other traumatic experiences, their experience of fear during the earthquake, and subsequent symptoms of PTSD, anxiety, and depression. All participants saw destroyed buildings, 90 per cent witnessed dead bodies, and 92 per cent encountered people with severe injuries. The fear they experienced during the earthquake was rated severe by 89 per cent of participants. Statistical genetic analysis showed that 41 per cent of the heritability of PTSD symptoms could be attributed to inherited genetic factors, compared with 61 per cent of the heritability of anxiety symptoms, and 66 per cent of the heritability of depressive symptoms. The researchers also found high genetic correlations for PTSD and anxiety, PTSD and depression, and anxiety and depression, suggesting that a large portion of the genetic liability for these disorders is shared. This research suggests that genetic factors are a more important cause of comorbidity among these disorders than environmental factors. The authors conclude that their findings hold promise for identifying the specific genes implicated in PTSD, anxiety, and depression.

Psychiatric Genetics, December 2008, v. 18: 261–266. Armen K. Goenjian et al., Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles, California.



Integrated treatment needed for concurrent disorders

Two new studies of co-occurring substance use and mental health disorders from the Centre for Addiction and Mental Health in Toronto highlight the need for better service integration in the treatment of these disorders. The first study collected data on 9,839 individuals seeking mental health treatment in Ontario. The data showed that 18.5 per cent had co-occurring mental health and substance use disorders. Rates of co-occurring disorders were even higher among young adults (55%), those with personality disorders (34%), and those receiving specialty tertiary inpatient care (28%). Individuals with co-occurring disorders were much more likely to have antisocial and challenging behaviour, more likely to have problems with the law, and had a higher risk of suicide or self-harm. The second study analyzed data on 36,984 Canadians from the 2002 Canadian Community Health Survey: Mental Health and Well-Being. It found that almost two per cent of Canadians have a concurrent disorder. People with mental health disorders had about twice the rate of alcohol use problems compared with those without mental health disorders, and they were three times as likely to have problems with illicit drugs. Conversely, people with substance use disorders were two to three times more likely to have other mental health disorders than those without substance use disorders, and those with substance dependence were five to six times more likely to have a co-occurring mental health disorder. The high rates of concurrent disorders seen in these studies point to the need for all parts of the mental health system to better respond to co-occurring disorders with integrated treatment.

Canadian Journal of Psychiatry, December 2008, v. 53: 800–821. Brian Rush et al., Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health, Toronto, Ontario.

Nurses can improve psychiatric inpatients' quality of life

Nurse interventions can significantly improve the quality of life of patients with schizophrenia in acute psychiatric wards, according to research from the University of Turku in Finland. The findings are based on interviews with 35 inpatients in seven acute psychiatric wards in Finland. Participants had diagnoses of schizophrenia, schizotypal disorder, or delusional disorder. They selected the most important areas of their lives and were asked to describe how nurses provided support in each of these areas and how they should support these areas. Participants emphasized empowering interventions involving discussion, showing an interest, and providing encouragement. They also indicated that they would like nurses to discuss patients' hopes and dreams more, as well as provide information about illness and care. They also wanted nursing interventions to be based on the patient's individual needs and expressed dissatisfaction with the many universal rules and regulations that did not take individual needs into account. Although participants indicated that they found their wards peaceful and safe, they reported that they were sometimes frightened by other patients and would welcome efforts to enhance feelings of security. The researchers conclude that shifting the focus of psychiatric nursing to quality of life would benefit patients, and that being aware of what impairs patients' quality of life would help nurses plan individually tailored interventions.

International Journal of Nursing Studies, November 2008, v. 15: 1598–1606. Anneli Pitkänen et al., Department of Nursing Science, University of Turku, Turku, Finland.

Beyond survival

Facing the past, claiming the present

BY TIM WALL

A sexual abuse survivor is involuntarily hospitalized in a psychiatric ward for suicidal behaviour. She writes in her journal: "I feel like I am being raped over and over again. I feel like I have to tell things to people I don't know who scare me with their presence, people who play tricks on me, who use their power to control me. These people ask question after question with no emotion, with no care for me. I am merely an object for analysis. Look at the poor freak."

IT IS ESTIMATED THAT ONE IN FOUR PEOPLE HAVE BEEN AFFECTED BY trauma and that one in 10 Canadians suffers from post-traumatic stress, according to the Canadian Mental Health Association. Trauma generally refers to experiences or events that are overwhelming and devastating to the victim, resulting in profound feelings of terror, shame, helplessness and powerlessness. For many, like the woman in the above fictional scenario, trauma is not simply an event or series of events – it is a life-defining experience that can shatter a person's sense of self and their view of the world. From the time that a trauma occurs, people with post-traumatic stress feel the effects in all aspects of their lives.

In social service and health care settings, people with trauma are at risk of being retraumatized because their behaviour may be misinterpreted and misunderstood. What is a normal response to an abnormal event is pathologized. This risk is largely due to our lack of knowledge and sensitivity to the needs and experiences of people with trauma. These experiences are so prevalent that service providers should assume that a significant number of people they serve have experienced some type of trauma. Yet we do not. This misunderstanding can create fear, retraumatize people and create ghettos of care within the health care system. Many service providers consider trauma a Pandora's box – something to be feared and avoided. Yet this avoidance only increases clients' sense of alienation, hinders their recovery and increases their risk of being retraumatized.

Given the high rates of trauma experienced by clients and the risk of retraumatization through insensitive practices, we as care providers must find ways to weave recognition of trauma into how we approach our work. This trauma-informed care needs to be integrated into the entire system of care – at the clinical, organizational and systemic levels. It does not mean that we must all do trauma therapy; it means that we must be sensitive to how trauma affects clients and how the care we provide, and the system itself, can retraumatize clients.

Every health care provider and social service worker can play a role in supporting people in their healing process, without doing actual trauma therapy. And not everyone who has experienced trauma requires trauma therapy. Practicing trauma-informed care does not apply only to our work with people who have experienced trauma – it is a philosophy of care that treats all clients with sensitivity and respect and acknowledges that the system itself can be traumatizing or retraumatizing.

Klinic Community Health Centre in Winnipeg, Manitoba, practices trauma-informed care, which grew out of the trauma recovery work we have been doing for more than 30 years. Much of our work has focused on developmental trauma, family violence, sexual assault and suicide bereavement. Our move towards trauma-informed care was motivated for many reasons, including our own self-preservation. As the number of referrals to our post-trauma program grew and far exceeded our capacity, it became apparent that the larger system of care needed to change. We identified various systemic issues:

THE TRAUMA-INFORMED SERVICE PROVIDER

Trauma-informed service providers acknowledge and understand the effects of violence and trauma on those with whom they work. This is evidenced by the fact that they:

- integrate an understanding of trauma throughout their programs;
- review policies and procedures to ensure prevention of retraumatization;
- involve trauma survivors in designing and evaluating services; and
- place a priority on trauma survivors' safety, choice and control.

Source: www.trauma-informed.ca

QUICK FACTS

90% of people with mental health problems have been exposed to trauma.

34–53% of people with mental health problems have experienced childhood sexual or physical abuse.

97% of homeless women with serious mental illness have experienced severe physical and sexual abuse.

87% of homeless women reporting abuse have experienced it as both a child and adult.

29–43% of people with serious mental illness have PTSD.

67% of people in substance use treatment report histories of childhood abuse and neglect.

50% of women in substance use treatment have a history of rape or incest.

Source: *Training Curriculum for Reduction of Seclusion and Restraint. Draft Curriculum Manual.* Alexandria, VA: National Association of State Mental Health Program Directors, 2005.

- While some people required more specialized trauma recovery services, many did not and would benefit from a service provider who was trauma informed but was not necessarily a trauma specialist.
- People already being seen by therapists were often referred to specialized services once they were identified as trauma affected, fragmenting their care and potentially sending a powerful, negative message.
- Trauma seemed to heighten service providers' anxiety, which clients undoubtedly sensed and reinforced their belief that something was very wrong with them. This discomfort reflected the general level of fear and ignorance that permeated the system around trauma issues.
- For people in need of longer-term counselling, limited resources were available and waiting lists were growing. Many clinicians were reluctant to take trauma clients because they believed this would require a long-term commitment. The health care and social services systems appeared reluctant to expand their involvement, focusing

instead on short-term and crisis services. It was becoming increasingly difficult for people seeking trauma recovery services to find and access them.

- There was growing frustration with policies and practices within various institutions that seemed to re-traumatize clients rather than provide a safe, healthy environment for recovery.
- There was great concern about the lack of resources and information for people affected by trauma in remote and rural areas.

In an effort to begin addressing these problems, Klinik, along with several partners, and with support from the provincial government and the Public Health Agency of Canada (PHAC), organized a provincial trauma forum to explore how to increase the capacity of organizations and systems to better meet the needs of people affected by trauma and to promote trauma-informed care. The forum produced various recommendations that were compiled into a report, available on Klinik's web site at www.klinik.mb.ca. A provincial trauma leadership committee was established to explore strategies for implementing the recommendations.

With funding from PHAC, a trauma-informed toolkit for organizations and service providers was developed and is available at www.trauma-informed.ca. (See p. 17 of this issue to test whether your practice is trauma-informed.) I hope over the next year to develop a multi-disciplinary trauma recovery consultation team to provide support to clinicians and that specific training about trauma-informed care and trauma recovery will be developed.

Much work lies ahead, but there is a climate of change and openness to working together to address this major public health and social issue. This change does not require large investments in new infrastructures; it depends on sharing knowledge and promoting awareness and understanding. Compassion, interest, curiosity and understanding cost little; ignorance, prejudice, apathy and misinformation cost everything. ■

Tim Wall is director of Counselling Services at Klinik Community Health Centre in Winnipeg, Manitoba.

TYPES OF TRAUMA

Interpersonal trauma

- childhood abuse: sexual, physical, neglect, witnessing domestic violence
- sexual assault: any unwanted sexual contact
- historical trauma: colonialization and the residential school experience of Aboriginal Peoples, which involved forcible removal from family, destruction of culture and language
- domestic abuse: physical, sexual, financial, spiritual, cultural, psychological
- torture and forcible confinement
- elder abuse: physical, sexual, financial, spiritual, psychological

External trauma

- war: combat, killing, fear of being killed, witnessing death and extreme suffering, dismemberment
- being a crime victim
- sudden death of a loved one
- suicidal loss
- loss of loved one to homicide
- sudden, expected loss: job, housing, relationship
- living in extreme poverty
- natural disasters
- accidents: e.g., vehicle, plane

Source: www.trauma-informed.ca

No safe haven

Restraints reform targets traumatizing hospital practices

BY ANNE PTASZNIK

TONIER CAIN'S VOICE TREMBLES AS SHE RECALLS BEING PUT INTO isolation on an inpatient psychiatric unit for refusing to go into her room. Had staff asked, she may have told them she was afraid of being alone in the dark.

As a young child, she had been sexually assaulted by acquaintances her mother would entertain at night in their apartment. Years later, Cain, who started drinking at age 9 to cope with her mother's abandonment and neglect, became addicted to crack cocaine. She was assaulted many times when she was homeless.

Being put into isolation triggered her trauma. "One of the worst things you can do to somebody who is a victim of neglect and abandonment is put them in a room and shut it," says Cain. So when staff would bring her a tray of food, she would not want to eat and would strike out, which landed her in restraints. Her memories of these experience in the psychiatric facility in Annapolis, Maryland, are vivid: "Now they're restraining me, they're holding me down – a rape victim, a victim of sexual assault – they're holding me down. That was scary, that was torture."

Over the past decade, recognition has been growing of the harms of using seclusion and restraint in psychiatric facilities. A Cochrane review in 2000 of 2,155 articles showed that beneficial effects of restraint and seclusion could not be substantiated and that many adverse effects were found, including death and injury. This recognition grows alongside the emergence of trauma-informed care, which acknowledges and responds to the high rates of lifetime trauma exposure, post-traumatic stress disorder (PTSD) and complex trauma reactions among people with mental health and substance use problems.

As Cain's story makes painfully clear, psychiatric treatment can be experienced as traumatic and retraumatizing, particularly if compulsory interventions such as involuntary treatment, restraint and seclusion are used. The practice of seclusion and restraint is precisely the kind of "treatment" that trauma-informed care advocates against.

"We still have hospitals that use seclusion and restraint for someone who curses at staff, lies down in the middle of the floor and won't get up, refuses to obey an order, won't go to bed, or refuses treatment programming," says Kevin Huckshorn, director of the Office of Technical Assistance of the U.S. National Association of State Mental Health Program Directors (NASMHPD). This happens even though U.S. federal law forbids the use of restraints or seclusion, except in the face of imminent danger.

Huckshorn had been the chief nursing officer of the South Florida State Hospital, a 350-bed facility serving people with serious mental illness and forensic patients, which had successfully reduced restraints and seclusion by 97 per cent. Her team's work now is to help train mental health providers across the United States and Canada to see seclusion and restraint not as a "therapeutic intervention" but as "a safety measure of last resort."

When Huckshorn was developing her training curriculum, she came across a program in Salem, Oregon, that took a trauma-based approach. Within two years, the program no longer needed to use seclusion and restraints, although that had not been the original goal. Huckshorn realized that by implementing a system that did everything possible to avoid traumatizing people on the unit – from being aware of one's tone of voice to monitoring noise levels to watching how patients are talked to and calmed down – seclusion and restraint would be reduced as a result. Huckshorn's six core strategies for reducing seclusion and restraint use (see p. 12 sidebar), reflects a trauma-informed care philosophy that recognizes the high number of people in the mental health and addiction system who have experienced trauma and are at risk of being traumatized by the system.

One of Huckshorn's colleagues has a unique perspective when she trains mental health providers to assume that the people they are dealing with have experienced trauma. Just four years after participating in a trauma program designed for pregnant women serving

time in prison, Cain is now the team lead for NASMHPD's National Center for Trauma-Informed Care. Cain says that her healing finally began when someone finally asked, not what was wrong with her, but what happened to her. Cain can easily tell when a facility has a trauma-informed approach: rooms are colourful and soft music is playing; patients and staff walk down the hallway side-by-side talking; there is no Plexiglas or boundaries marked out on the floor keeping patients away from staff.

Dr. Joan Gillece, program manager of NASMHPD's Seclusion and Restraint Reduction Initiative and project director of the National Center for Trauma-Informed Care, says it is critical to inform staff about alternative strategies, including sensory approaches, patient safety plans and therapeutic communication. Otherwise, staff feel they are being asked to give up the only tools they have to control their environment. On site visits, Gillece talks with direct care staff about what it feels like for them to take someone down and the importance of getting support if they have experienced trauma themselves. Once staff come to understand how retraumatizing restraints can be to someone who has been held down against their will or raped, they begin to move away from a "we versus they" culture.

For this approach to be successful, leadership involvement is critical, creating a learning environment where staff can practice different approaches and not be afraid of making mistakes. It is also important that the administration participate along with the direct care, maintenance and kitchen staff, peer specialists and community partners in learning how to determine whether a person is being triggered and having difficulty self-soothing and the actions to take in response.

Another tool discussed in training is sensory objects. Gillece tells about one young woman who was regularly kept in seclusion and restraints because staff could not get her to stop self-cutting. Gillece spoke with the woman and discovered that hearing a male staff member scream triggered her trauma. When Gillece asked what would help soothe her, it was the very items the woman found calming – earphones so she could listen to religious music and a pen to write – that staff had taken away for fear she would hurt herself with them. Gillece worked with the staff to determine a safe way for the woman to have access to these items when she needed to self-soothe.

But what about clients who cannot seem to be de-escalated or negotiated with, for example, an intoxicated person acting violently who is brought to emergency by police who are having difficulty subduing him? Huckshorn says she realizes that there are situations where seclusion and restraint may be necessary, but that even in such situations, it remains important to create the calmest, safest environment, where people are respected and are given as much empowerment and dignity as possible and the opportunity to make some choices. She says it is essential in these situations to have well-trained staff who know how to build a therapeutic alliance with the person very quickly and help them settle down with the goal of removing the restraint as quickly as possible.

For people who are psychotic when they are admitted, Huckshorn recommends providing a quiet safe place and medication, and waiting to develop the treatment plan, just as would happen with someone who had been in a serious car accident. But once the person starts to be able to talk, "You don't continue to treat them like they can't," says Huckshorn, adding that staff must immediately begin to involve them. Advance directives or personal safety plans, which out-

EDUCATING NURSES ABOUT RESTRAINT REDUCTION

- Provide a clear statement about the goal of restraint reduction.
- Allow opportunity to discuss feelings, fears and hesitations.
- Provide information about the new standards for restraint and seclusion use and the rationale, including statistics on deaths, information on law suits, and shift in public opinion.
- Teach a variety of de-escalation techniques, including asking clients what strategies have succeeded in calming them down.
- Practice developing individualized treatment plans.
- Role-play de-escalation strategies and provide feedback.
- Ensure that the trainer works in a clinical setting to increase credibility.
- Evaluate educational session.
- Acknowledge and reward staff who are working towards achieving a positive therapeutic culture.

Source: "Staff resistance to restraint reduction: Identifying and overcoming barriers," *Journal of Psychological Nursing*, May 2007.

stressed or triggered, are useful for preventing escalation.

Courtney, a former inpatient at the Centre for Addiction and Mental Health (CAMH) in Toronto, has experienced restraints. She says that advance plans may have some value, but they need to be "administered properly, through people that you feel care about you." She believes that staff need to spend more time circulating through their units, building relationships with patients. She also recommends that independent, objective observers be available whenever a code white, indicating a psychiatric disturbance, is called, as people on the unit can be seen as lacking credibility if they complain about how they are treated.

At the same time, the second-year law student understands nurses' concerns about violence in the workplace. She recommends that they be involved in developing, implementing and evaluating anti-restraint policies. She also proposes that patients be engaged in individualized programming according to their interests, rather than having no choice but to sit around watching television and waiting for medications to take effect.

Cheryl Rolin-Gilman, an advanced practice nurse, works with CAMH's addictions and women's programs, which actually provide trauma treatment through individual and group programming. She says that providing structure can "limit agitation because if clients have nothing to do during the day and they are already overwhelmed by their feelings or their spiralling negative thoughts, there's nothing to pull their focus away." Rolin-Gilman says the concept of trauma-informed care was introduced CAMH-wide at a two-day leadership training about seclusion and restraint reduction a year ago.

The leadership training was just one step in CAMH's overall efforts to reduce seclusion and restraints. CAMH developed a least restraint policy in 2002 after the Psychiatric Patient Advocate Office conducted a review in 2000 of the seclusion and restraint practices in Ontario's provincial psychiatric hospitals and the former Queen Street Mental Health Centre, now part of CAMH. More than 50 per cent of clients interviewed said that at the time they were restrained or secluded, they had not posed a threat to themselves or others.



10 TIPS FOR INCREASING WOMEN'S SAFETY

Women who had been abused were interviewed for a study published in the *Canadian Journal of Nursing Research* in 1999 and for an Australian report from the Victorian Women and Mental Health Network's Project. Women cited 10 factors that increase their sense of safety on inpatient units:

1. Locate women's and men's bedrooms in separate corridors.
2. Have lockable bathroom and bedroom doors.
3. Have the option of a female staff available at night.
4. Provide more opportunities for communication and therapeutic contact with staff.
5. Allow a low light to be kept on at night.
6. Have staff available to speak with at night.
7. Be asked prior to admission what helps them feel safe.
8. Ensure that staff respect them, take them seriously, believe them, listen to them, and show genuine concern.
9. Be included in treatment planning so they feel they are being listened to.
10. Provide access to the television lounge or other communal space in the evening.

Almost half did not know what was required of them to be released once in restraint. Clients also reported that staff were not available for them to talk to about their fears while in restraints or to provide emotional support. In response to these findings, CAMH managed to successfully reduce the number of incidents of restraint by 67 per cent from 2005 to 2008. It was prompted to further action by the recent coroner's inquest looking into the restraint-related death of CAMH forensic inpatient Jeffrey James in July 2005. The inquest recognized CAMH's work in this area and recommended that the organization take a leadership role with other psychiatric facilities across the province.

"We aspire to provide safe therapeutic care and services in a restraint and seclusion-free environment," says advanced practice nurse Athina Perivolaris, who co-leads CAMH's Prevention of Restraint and Seclusion Initiative. She adds that the initiative, which is founded on the six core reduction strategies identified by Huckshorn, is focusing on updating CAMH's restraint and seclusion policy to incorporate best practices and the coroner's recommendations. This policy will be shared with all psychiatric facilities in Ontario. CAMH has also had several external requests for consultation and collaboration regarding the initiative. In response to these recommendations, CAMH has already increased the number of peer support workers and is providing ongoing education sessions about prevention and the use of alternatives, and is offering consultation to staff to support clients in managing their distress.

Jennifer Chambers, co-ordinator of the Empowerment Council at CAMH, says that many of the strategies now proposed by experts are changes that clients have been recommending for years. "For example, consumer/survivors have maintained that if someone is in restraints, they should have support and comfort always available to them, and an explanation of how to get out of restraints," she says. She is pleased that their suggested policy changes have now largely been included in the inquest recommendations.

Courtney sums it up this way: "A change in the environment, a complete culture change, is the only real way you can reduce restraints and violence and make everybody happy." ■

6 CORE REDUCTION STRATEGIES

1. Leadership toward organization change
2. Use of data to inform practice
3. Full inclusion of consumers and families
4. Rigorous debriefing (incident review)
5. Workforce development
6. Use of seclusion and restraint prevention tools

The document *Six Core Strategies for Reducing Seclusion and Restraint Use*, developed for the National Technical Assistance Center, is available at www.nasmhpd.org. Under "Publications," select "Office of Technical Assistance (OTA) Publications and Reports."

The verdict and recommendations from the coroner's inquest are available on the Ministry of Community Safety and Correctional Services website at www.mcscs.jus.gov.on.ca. Under About Your Ministry, choose "Chief Coroner" and then "Verdicts and Recommendations." Do an alphabetical list search on the name "Jeffrey James."

Helping to heal the scars

What does trauma-informed care look like?

BY TAMMY RASMUSSEN AND JULIA BLOOMENFELD

KIM IS A 38-YEAR-OLD WOMAN WITH TWO CHILDREN, AGES 7 AND 8. As a child, she experienced physical and sexual abuse and now struggles with flashbacks, nightmares, hypervigilance, depression and anxiety. At 14, Kim began drinking and cutting herself. By her late teens, she was binge drinking most weekends. At 25, she moved in with her partner and stopped drinking when she became pregnant. When they separated three years ago, Kim began to drink occasionally. After being sexually assaulted by a stranger a year ago, she began drinking daily. Child welfare became involved and Kim's children were placed in the father's custody. For the first time, Kim reached out for help.

Kim's experience with traditional care

Kim enters a co-ed treatment program and is triggered into flashbacks after a male client flirts with her. The program is unaccustomed to working with trauma issues, so Kim is sent to the local hospital for mental health support. There, she becomes increasingly agitated and is restrained, which causes her to spiral into painful memories. She is told that she must first deal with her substance abuse, so she is sent back to the residential program. When flashbacks and intrusive memories continue and trigger Kim to drink, she is discharged. Without supports in the community, Kim's trauma responses and other problems intensify.

Kim's experience with trauma-informed care

Kim's child welfare worker refers her to a substance use treatment agency for assessment. The receptionist shows her into the pleasant waiting room. A female counsellor invites Kim into a private office and explains the assessment process. Kim says she is nervous and the counsellor comments on Kim's courage. She is informed of her privacy rights and exceptions to confidentiality. The counsellor explains that the assessment includes questions about trauma and that Kim needs only to share what is comfortable for her.

During assessment, Kim begins to dissociate. The counsellor, like all clinical staff at the agency, is trained in first-stage trauma work and helps Kim re-orient to the present and become safe and grounded. She reassures Kim that in treatment she can work on her greatest concerns – her flashbacks and substance use – at the same time. The counsellor asks Kim about her strengths, which she identifies as her motivation to change.

After a few sessions, the counsellor recommends that Kim attend an out-of-town women's residential substance use program that is trauma informed. Plans for withdrawal management are made. During orientation, staff invite Kim to discuss any concerns and she mentions having nightmares of the sexual assault. A plan is made for Kim to use her MP3 player at night, as she finds listening to music soothing. On particularly difficult nights, she can sleep on a couch in the living room.

During the first week, physical and emotional safety are defined in group therapy, where Kim learns a grounding exercise to help her deal with cravings and post-traumatic stress responses. When Kim's trauma issues emerge, she is encouraged to speak about the impact in the present – its connection to her alcohol use – and to identify and practice positive coping strategies.

With her primary counsellor, Kim explores how to cope with intrusive memories and gets information on dealing with flashbacks. She is informed about an upcoming fire drill, as unexpected loud noises trigger her. Kim also works on a commitment to herself to avoid self-cutting, and coping strategies are identified to enhance her safety.

During the second week, Kim tells her counsellor that she has been experiencing overwhelming memories and panic during the women and relationships sessions. She worries that she will be discharged from the program if she needs to leave the room. They speak about the importance of pacing and identify parts of the program that while triggering are still manageable for her. They agree that if Kim is feeling overwhelmed in a session she will leave and practice self-care strategies.

Over time, Kim is able to use these strategies to remain in the sessions longer. She makes connections between her substance use, mental health issues, and trauma and begins to feel validated regarding her traumatic responses.

During her final week, Kim develops a continuing care plan that incorporates strategies for emotional and physical safety and relapse prevention. When she expresses concern about her antidepressant, the counsellor organizes an assessment with the agency's consulting psychiatrist, who has expertise in substance abuse, to review Kim's medication options with consideration for her trauma responses. A telephone conference is also held with Kim and her service providers, including her child welfare worker, to discuss aftercare. Kim decides to attend a relapse prevention group and a parenting program for women with substance use issues.

Kim returns to her community and works on rebuilding her relationship with her children and strengthening her coping skills. After several months in the relapse prevention group, Kim arrives distraught. She explains that last week her daughter turned 8, which triggered flashbacks she has never had before. Kim drank in response but does not want to return to old patterns. The counsellor validates her courage to share this and reinforces her determination to heal.

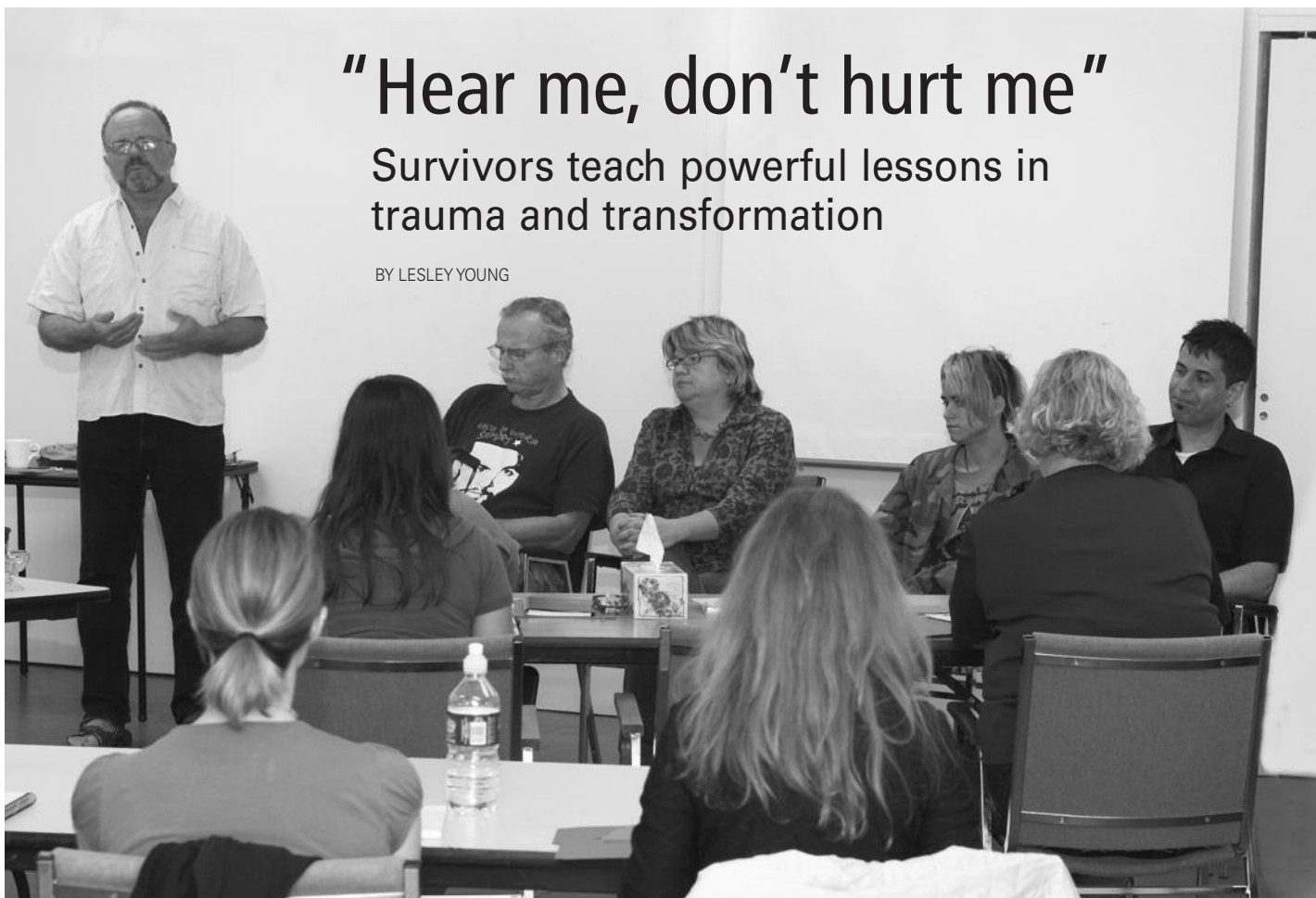
Kim and her counsellor connect with her child welfare worker to discuss the nature of the healing process and identify further supports. Kim accepts a referral to a trauma therapist who can work with her through the stages of trauma recovery. Kim continues to strengthen herself and work with her ex-partner and child welfare to one day have her children home again. ■

Tammy Rasmussen is a trauma counsellor at the Jean Tweed Centre. **Julia Bloomenfeld** is the centre's director of Clinical Services.

"Hear me, don't hurt me"

Survivors teach powerful lessons in trauma and transformation

BY LESLEY YOUNG



Tom Regehr and CAST cosumer panel talk with front-line professionals

TWO OF TOM REGEHR'S BEST MEMORIES DURING HIS STRUGGLE WITH alcohol addiction are heart-rending, singular moments of trauma-informed care. Of course, living on the streets of downtown Toronto, the 30-something Regehr had no way of knowing that at the time. It was long after recovery, during therapy for his own childhood and adult acute traumas, that he came to understand why those experiences ultimately changed his life.

He can't recount them without choking up. The first came from a friend, Josie, who ran into him after he'd been homeless for years and offered him an apartment in her house for three months in exchange for work around the yard. "While I was there I had a chance to see how much my life sucked," says Regehr. His drinking had destroyed a successful landscaping career he'd built in his 20s, a time when he had managed to keep his nightly drinking and drug binges from interfering with his in-demand design skills, although he was bouncing from sofa to sofa.

"One day she knocked on the door and there was something in her hand. I knew I wasn't looking very good. She said, 'Tom, I need you to fix the garage, because next month I need you to work on the fence. By the way, here are some mashed potatoes.' Well, I squared up my shoulders. Everything I needed was there. She used plain talk. She mentioned a positive future. And the mashed potatoes said I care about you. That was my turning point." That was a quiet but pro-

found event that reflected many of the qualities of trauma-informed care.

Regehr would face an uphill battle yet, however. As he puts it, "I was angry, volatile and antisocial." But he was also determined. He managed to hold onto accommodations, despite the fact that he couldn't quit drinking. The second memory that rocked his world came from a Region of Peel helpline worker, who put him in touch with an addiction agency. "She was kind. She had a gentle tone. At the end of the call, she said, 'Tom, you can call back for the number any time.' Fifteen years later it still makes me cry. She was present enough to know I might not have a pen because I was in a pickle."

Regehr says these memories affected him deeply because they are shining examples of how to interact with mental health and addiction clients in ways that are sensitive to preventing further trauma. He adds that he was lucky to eventually find a therapist who provided trauma-informed care, which ultimately led to healing, 13 years after quitting alcohol.

Today, after founding CAST (Come and Sit Together) Canada in 2000, which has evolved from a support group into an education forum that includes panels and speaking engagements, 51-year-old Regehr is determined "to change the world." He recently created a trauma-informed care initiative, which will launch with a conference in London, Ontario, in June. The goal is to raise awareness among front-line workers and other professionals. He says these people are

unprepared by life to deal with trauma issues, personally or in a helping role, and are under-prepared by post-secondary education institutions and largely under-supported in the workplace.

Regehr knows this to be true not just because of his own experience. Over time – after 60 or so CAST Canada panels – he discovered through the passionate questioning of audience members that front-line professionals were looking for detailed insights into his treatment experience in order to learn how they could do a better job with their clients who may have trauma issues. Regehr and other addiction and mental health clients who have participated in CAST Canada panels, have been sharing their insights and experiences to give these helping professionals first-hand tips for what a trauma-informed systems looks like.

Regehr could explain how his trauma therapist gauged his individual potential and determined he would respond well to having more control. At his third session, she sent him away with homework, to read books such as Judith Herman's pivotal *Trauma and Recovery*. The insights in those books gave Regehr affirmation regarding his own personal traumas, but equally important, they empowered him.

"[My therapist] enabled me in her demeanor and in her basic language, to normalize large-scale emotions," he adds. Regehr points out how, for more than a year, he screamed and whaled in his sessions, and how his therapist never once "acted OK with it. She *was* OK with it." In order to feel confident, comfortable and respectful for clients – Regehr suggests that front-line workers develop boundaries. "Time and time again, I hear – and you don't get better evidence-based information that this – consumers feel strongly that when helping professionals did a good job of setting their own boundaries, they felt safe with their own emotions." And the best way to truly honour emotions within boundaries, suggests Regehr, is to think of them as real, whether they make sense or not, recognizing the power the emotion has over clients, and giving them hope that they can live with them.

Trauma-informed care involves a fine balance between control and coercion, the latter of which can be retraumatizing, says Regehr. "I feel strongly that there is a time and a place for the helping professional to take direct control over small decisions for the individual," he says. Similarly, he suggests some clients need firm, plain speak, as opposed to coddling, which is misdirected kindness. For example, "we need to be told, 'Go take a bath.'"

One of the most compelling insights driving Regehr's trauma-informed care initiative is learning from members of the consumer panels that for almost all of them, the most helpful professional was someone who was trauma aware and trauma informed, but not actually doing trauma work. "That just goes to show you that how people are treated is what brings them to a point where they are actually able to heal."

Regehr's moving memories from his own experience are examples of another finding from his panels. "Patients who think back to their most helpful moment from a helping professional say, in almost 100 per cent of cases, that they were short interventions, short conversations with absolutely clarity," he says. "Real trauma work doesn't mean excavation. You can be a person who helps change lives simply with the right demeanour and future-forward language. And you can do that without being afraid." ■

For more information about CAST's trauma-informed care initiative, visit www.cast-canada.ca

5 TIPS FOR INVOLVING CLIENTS

By soliciting input and participation from clients, you send a message of partnership and recovery. Regehr offers ways to include clients at all levels of system, service and evaluation efforts.

1. Make a commitment to hiring former clients and creating visible peer support. Regehr suggests involving former clients in welcoming new clients. "First contact can be staggeringly important," he says. "Sitting in a waiting room alone can be awful."
2. Encourage clients to run a support group that provides a safe, productive place with a progressive involvement model, and that isn't facilitated by a professional.
3. Use clients in awareness raising events, such as planning public educational events and designing posters and websites.
4. Recognize clients' changing needs. As they heal, what they need and want may change. "Allow for graceful exits," says Regehr. At CAST, panel members only ever commit to one event at a time.
5. Include clients on advisory boards and committees.

CREATE A SAFE SPACE FOR TRAUMA SURVIVORS

In an article about the role of consumer-survivors in trauma-informed systems, Laura Prescott, founder of Sister Witness International, suggests how organizations can operationalize their commitment to client involvement through concrete steps. In addition to offering strategies for developing a strategic plan and hiring practices that involve trauma survivors, she offers these tips for creating accessible and welcoming environments in meetings that have not traditionally considered clients as key stakeholders.

Plan enough time. Abusive histories along with experiences of social, economic and political devaluation can leave clients cautious, self-conscious and afraid of reprisal. Scheduling enough time for them to participate and reflecting back what they say conveys important and respectful messages about valuable contributions.

Hold meetings in neutral places. Meetings scheduled in treatment centres or other institutional settings can trigger painful memories for trauma survivors. The presence of power, authority and threat of force will influence the extent of direct, honest dialogue. Don't assume that treatment settings are safe, convenient places to meet with individuals still in treatment.

Adapt physical spaces. Avoid blocking entries and exits, overcrowding and sitting behind women survivors. When setting up a room for a meeting, ask clients what seating arrangements they are most comfortable with.

Source: "Defining the role of consumer-survivors in trauma-informed systems," *New Directions for Mental Health Services*, no. 89, Spring 2001.

Expanding the circle of care

What does trauma-informed care mean for family-centred care?

BY KIM GOGGINS

IN THE 32 YEARS SINCE MAUREEN FOY'S DAUGHTER WAS DIAGNOSED with paranoid schizophrenia, the experiences Foy has witnessed her go through are vividly ingrained in her mind. She has watched her daughter desperately pounding on the window of an isolation unit, crying for help; she has seen her handcuffed and taken away, not because she was violent, but because she was sick and frightened; she has sat beside her for hours in an emergency waiting room as she rocked back and forth in a catatonic state.

One of Foy's most painful memories is of her absolutely panicked daughter running through the hallway of a hospital, trying to escape. Knowing she needed to stop her daughter before she reached an outside door, and seeing no other choice, the five-foot-one, 105-pound woman tackled her to the ground.

"I will never experience anything as painful as that ... to have to physically tackle her, which goes against everything I believe in," says the soft-spoken 74-year-old. "It was an offence to myself and to her."

Foy's story is a painful one, reflecting not only the anguish of mental illness, but also the traumatizing potential of the mental health system – for both clients and families. As mental health organizations begin to recognize the need to work from a trauma-informed philosophy – one that acknowledges the pervasiveness of trauma in the lives of clients and how the system itself can traumatize clients – some, like Foy, wonder what this means for family-centred care. The fact that Foy was not allowed to stay with her daughter while she was in distress sends a clear message that families are not important.

In a system that family advocates say traumatizes the family by disregarding and excluding them, many worry that a trauma-informed system may further limit family involvement because

people working with clients could become more suspicious and cautious of families.

"I go back to a time, 25 or 30 years ago, when we had 'schizophrenogenic mothers,'" says Foy. "In other words, if children had schizophrenia, the mother was mainly responsible. That bias against mothers has carried through, even though mental health people do not want to talk about it."

"The whole idea of families being traumatized and disrespected is talked about incessantly at the Centre for Addiction and Mental Health (CAMH) Family Council," says Foy, who is involved with the council. "Families come for peer support – 400 family members last year, and the resource centre is only open two-and-a-half days a week."

In a 2004 CAMH report, "Putting Family-Centred Care Philosophy into Practice," families shared their frustration at being unable to obtain information about their loved ones and being excluded from care planning. A study of 228 families cited in the report found that only 31 per cent thought they were sufficiently involved in treatment planning.

The Family-Centred Care Initiative at CAMH is pushing for a policy that will see families (or the client's support network) involved in all aspects of treatment. The committee consists of staff and family members, and over the last five years has created this policy to deal with lack of family acknowledgement and inclusion.

Karyn Baker, executive director of the Family Outreach and Response Program at CAMH, understands the concern. Ten years after her program was developed to align family groups with consumer/survivor programs, there are still challenges, as families that advocate more involvement are often at odds with members of consumer groups who were affected by trauma within their families.

"It's complicated, but I think a lot of prejudging goes on – that because families may have been involved in direct trauma they can't somehow be helpful in the recovery process or don't need their own support in recovery of whatever led them to committing this sort of traumatic act," says Baker. She says the reality is that a lot of people stay in touch with families that have caused trauma: "That's what we see here, so working with the whole family in terms of healing, moving forward, and understanding the experience and its effects can be helpful for the person recovering," she says, adding that clients must first agree to have their families involved.

Family advocates insist that a trauma-informed system must recognize that families also experience trauma when a relative has a serious mental illness or addiction. "Like clients, families go through stages themselves when they realize a family member has a problem," explains Dr. Caroline O'Grady, an advanced practice nurse researcher and clinical project scientist in the Concurrent Disorder Service at CAMH. "It's an experience of shock, and then there's loss and grief for the person. It's like being on another planet all of a sudden. It's shocking and for the families, that's extremely traumatizing." ■

HOW TO INCLUDE FAMILIES IN TRAUMA-INFORMED CARE

O'Grady and Baker offer these tips for working with families:

- Listen to family members' concerns about the situation and validate them.
- Be sensitive to families as being victims of trauma as well and provide referrals so they can get help.
- Treat families as collaborators and partners instead of a nuisance.
- Empower families by educating them, and acknowledge their own expertise about their loved one.
- Teach families that clients need to be listened to as well, and if they don't want their family involved right away, the family will be directed to services to help them.
- If any kind of restraints are used, families need to be debriefed afterwards, especially if they witness it.
- Families need to be told the protocols and processes that will be followed, the reasons for them, and what to expect next.

ARE YOU TRAUMA-INFORMED?

A service provider checklist

Answer “yes” or “no” to help you decide whether your practice is trauma-informed.

Knowledge

- Y N
- ■ Can you explain to a client what trauma is, including effects?
 - ■ Do you recognize the signs and symptoms of trauma, even if a person does not verbally tell you?
 - ■ Do you know what PTSD is? Can you explain it?

Assessment

- ■ Do you routinely ask about previous trauma and how it is impacting trauma survivors?
- ■ Do you ask about past or current use of drugs or alcohol?
- ■ Do you routinely ask about mental health issues related to trauma?

Comfort level

- ■ Are you comfortable asking about traumatic experiences and hearing the responses?
- ■ Are you willing to actively listen to difficult feelings and emotions that may arise?
- ■ Are you comfortable talking about trauma experiences?

Relationship building

- ■ Is establishing trust and safety a priority in your work with people?
- ■ Do you make sure clients are comfortable with the questions you ask on assessments?
- ■ Do you try to establish a genuine, caring connection with clients?

Responding to disclosure

- ■ Do you acknowledge to the client the difficulty and courage involved in talking about trauma?
- ■ Do you respond to disclosure with belief and validation?
- ■ Do you encourage the client to disclose only what they are comfortable with sharing?

Coping

- Y N
- ■ Do you ask clients how they cope with the difficult feelings surrounding the trauma?
 - ■ Do you ask clients how they cope with difficult behaviours that may result from the trauma experience, e.g., substance use?
 - ■ Do you acknowledge the link between trauma, mental health and addiction?

Personal attitudes and beliefs

- ■ Do you believe that trauma survivors are resilient and able to recover?
- ■ Do you believe that you can affect positive change for clients?
- ■ Do you dispel the myths surrounding trauma in your work with people?

Resources

- ■ Are you familiar with community resources for trauma survivors?
- ■ Do you refer clients to trauma-recovery services?
- ■ Do you advocate on behalf of clients who need assistance in accessing resources?

Strengths-based

- ■ Do you focus on clients' strengths and resources?
- ■ Do you try to instil a sense of hope and change for clients?
- ■ Do you work as a team with the client, letting them make decisions about their care?

Cultural awareness

- ■ Do you consider clients' cultural backgrounds when making referrals and discussing community resources?
- ■ Do you get an understanding of the issues from clients' cultural perspectives?
- ■ Do you make the effort to provide culturally appropriate services when requested?

How did you score? Total Y ____ Total N ____ Date: ____

Revisit this survey after putting the Trauma-Informed Toolkit (www.trauma-informed.ca) into practice and re-evaluate.

An organizational checklist

Answer “yes” or “no” to help you decide whether your workplace is trauma-informed.

Philosophy

- | Y | N | |
|--------------------------|--------------------------|--|
| ☐ | ☐ | Does your organization include trauma recovery as part of its mandate and /or programming? |
| ☐ | ☐ | Does your organization subscribe to the evidence-based, best practice trauma-informed treatment model? |
| ☐ | ☐ | Does your organization support efforts to minimize the possibility of retraumatization? |

Staff training

- | | | |
|--------------------------|--------------------------|---|
| ☐ | ☐ | Do you train staff on the dynamics and impact of trauma? |
| ☐ | ☐ | Do you encourage your staff to attend information sessions and workshops on trauma? |
| ☐ | ☐ | Do you train staff in communication and relationship-building skills? |

Administration

- | | | |
|--------------------------|--------------------------|--|
| ☐ | ☐ | Do you have trauma survivors on your board of directors? |
| ☐ | ☐ | Does your mission statement address trauma survivor input and participation? |
| ☐ | ☐ | Are there trauma survivors on your administrative team? |

Suicide prevention

- | | | |
|--------------------------|--------------------------|---|
| ☐ | ☐ | Are all of your staff trained in suicide intervention/prevention? |
| ☐ | ☐ | Are suicide assessments included in the assessment and intake process? |
| ☐ | ☐ | Does your organization acknowledge the impact of suicide on clients and staff, and include supports around suicide grief? |

Cultural awareness

- | | | |
|--------------------------|--------------------------|--|
| ☐ | ☐ | Do you provide training for staff on cultural competency? |
| ☐ | ☐ | Does your organization strive to include ethnic and minority groups in staffing and client programs? |
| ☐ | ☐ | Does your organization stay current on issues facing immigrants, refugees and Aboriginal people? |

Hiring practices

- | | | |
|--------------------------|--------------------------|---|
| ☐ | ☐ | Does your organization include experience in working with trauma survivors in job descriptions? |
|--------------------------|--------------------------|---|

Y N

- | Y | N | |
|--------------------------|--------------------------|--|
| ☐ | ☐ | Does your organization hire trauma survivors? |
| ☐ | ☐ | Does your organization hire Elders or those involved in traditional/spiritual healing practices? |

Policies and protocols

- | | | |
|--------------------------|--------------------------|---|
| ☐ | ☐ | Does your organization include universal screening for trauma for all clients? |
| ☐ | ☐ | Has your organization ensured that current policies and protocols are not hurtful or harmful to trauma survivors? |
| ☐ | ☐ | Does your organization involve trauma survivors in the creation of policy and protocols? |

Survivor involvement

- | | | |
|--------------------------|--------------------------|---|
| ☐ | ☐ | Does your organization include trauma survivors in program development and evaluation? |
| ☐ | ☐ | Does your organization include trauma survivors in service provision in paid or voluntary roles? |
| ☐ | ☐ | Does your organization get assistance from trauma survivors when developing procedures that are potentially invasive? |

Link between trauma, mental health and addiction

- | | | |
|--------------------------|--------------------------|---|
| ☐ | ☐ | Does your organization acknowledge the links between trauma, mental health issues and addiction in its policies and procedures? |
| ☐ | ☐ | Does your organization provide training and knowledge to staff on co-occurring disorders? |
| ☐ | ☐ | Does your organization's screening procedure include mandatory trauma assessment where addiction issues are present? |

Support and supervision for providers

- | | | |
|--------------------------|--------------------------|--|
| ☐ | ☐ | Does your organization have mandatory supervision for staff working with trauma survivors? |
| ☐ | ☐ | Does your organization acknowledge the impact on those who work with trauma survivors through vicarious trauma workshop opportunities? |
| ☐ | ☐ | Does your organization foster a climate of sharing feelings and experiences related to clients in a safe and confidential setting? |

How did you score? Total Y ____ Total N ____ Date: ____

Revisit this survey after putting the Trauma-Informed Toolkit (www.trauma-informed.ca) into practice and re-evaluate.

The Twenty-Four Carat Buddha: Healing trauma through fables

In *The Twenty-Four Carat Buddha*, psychologist Maxine Harris, co-founder of Community Connections, the largest mental health agency in Washington, D.C., demonstrates the value of fables as an effective means to self-exploration and truth-seeking. In our search to make sense of our lives, we often turn to stories because they are paradoxically personal and impersonal at the same time, thus allowing us to take stock of our values and make moral sense of our lives in a way that is safe and non-threatening.

These stories are a gift to anyone interested in raising their level of consciousness. Published by Sidran Institute Press, which specializes in resources on traumatic stress and dissociative conditions, the 24 fables can also provide a vehicle to help people with trauma find value, strength and peace.

Despite what the book's title might suggest, the fables do not reflect a specific faith-based orientation. Rather, they explore the universal human condition. The Buddha, like other great spiritual leaders, touched people's hearts by speaking in the language of emotion, with which anyone can identify, regardless of their religious or spiritual orientation.

Using fables as a means of self-discovery

enables us to become aware of the ego's moves because the focus on the tale holds the reader in a way that makes honest self-reflection and emotional intensity safe, thus allowing the reader to recognize and address issues the fable has called forth. These stories do not pass judgment or offer advice.

The structure of the book invites varying levels of self-discovery. The first part contains the stories themselves. The second part serves as a therapeutic guide, in which Harris provides commentary and an evocative set of questions for each fable. The reader can contemplate these questions alone or with a counsellor or group of friends or colleagues.

I have used the fables myself in clinical practice with women with trauma and substance use and mental health issues. Guided by the commentary, I selected several fables that would be meaningful to my clients who participate in a weekly journal writing group in a women's inpatient unit. We also used self-reflection questions from the appendix. One of the fables, "Inktomi," proved an effective tool to help clients differentiate healthy self-improvement from the powerful longing to be different that arises from a lack of self-acceptance. The exercise prompted a

level of engagement and self-reflection that the women found gratifying. Some told me that the fables engaged their imagination in meaningful ways, and that by putting themselves in the position of various characters in the fables, such as Inktomi, a spider, they could connect issues emerging from the fables with issues in their own lives. One client later told me that through exploring the fable, she was able for the first time to confront how a scar from an automobile accident had restricted her life and to discuss it with her mother.

These engaging fables teach lessons about the dilemmas and choices we face in life. They are also a valuable tool that professionals working with trauma survivors may want to use to help these people embark on the journey of self-discovery in a safe, non-threatening way.

The Twenty-Four Carat Buddha and other Fables: Stories of Self-Discovery. Maxine Harris. Sidran Institute Press, Baltimore, 2003, 192 pp., \$13.95US.

Ann Dixie is an occupational therapist with the Women's Program at the Centre for Addiction and Mental Health in Toronto.

downloaded

SHEILA LACROIX

Trauma-informed care

National Center for Trauma-Informed Care

<http://mentalhealth.samhsa.gov/nctic>

SAMHSA's Center for Mental Health Services established the NCTIC to offer technical assistance for supporting and implementing trauma-informed care throughout publicly funded U.S. systems and programs. The site offers an overview of the concept and examples of trauma-specific interventions that can be incorporated into existing services.

National Child Traumatic Stress Network www.nctsn.org/nctcs

The NCTSN promotes standards for trauma-informed care for service providers in child-serving systems. See the Tools You Can Use box on the main page to access resources from NCTSN and other organizations. The NCTSN resources are provided for different audiences, including the public, educators and mental health and medical professionals. Most are downloadable.

Homelessness Resource Center (SAMHSA) www.homeless.samhsa.gov

In addition to publishing resources, this site serves as a portal to resources from other agencies. If you search the term "trauma-informed," you will access to resources such as *10 Tips for Recovery-Oriented, Trauma-Informed Agencies* and *A Long Journey Home: A Guide for Creating Trauma-Informed Services for Mothers and Children Experiencing Homelessness*.

BC Centre of Excellence for Women's Health www.bcccewh.bc.ca

The 2002 report *Violence and Trauma in the Lives of Women with Serious Mental Illness: Current Practices in Service Provision in British Columbia* indicates that existing approaches to dealing with violence and mental health are primarily biomedical and neglect histories of abuse and vulnerability to ongoing abuse. This approach risks retraumatizing women in treatment through misdiagnosis, lack of support and marginalization. The findings and recommendations are relevant to developing trauma-informed mental health services. To locate the report, see Publications/Resources.

Should inpatient psychiatric wards be gender segregated?

BY KATHY HEGADOREN

Historical references conjure up negative images of crowded insane asylums, where men and women segregated by gender were housed for years or decades. Then came the enlightened age of social psychiatry, where social determinants of mental health came to the forefront, prompting re-examination of gender-based segregation of inpatients. If men and women were going to rejoin the “outside world” in a socially acceptance manner, the institutional environment needed to become more “normalized.” This ushered in the movement to establish mixed-gender inpatient units.

Fast forward to the age of deinstitutionalization, where the average lengths of stay began to precipitously fall and where community services were deemed more humane, naturalistic and therapeutic. Large mental health hospitals began to close and inpatient treatment was mostly provided within large urban tertiary care hospitals. Where the average length of stay was four to six weeks, therapy groups could focus on interpersonal skill development and social learning in formal and informal ways. There was an inherent belief that developing communication and self-reflection skills was enhanced or at least made more socially appropriate by a more naturalistic framework of mixed male/female groups.

But the average length of stay continued to fall. Hospital closures, increased recognition of mental health emergencies, the emergence of “crisis beds,” day programs and partial hospitalization programs and the development of specialized programs all contributed to shorter lengths of stay. (Currently the average length of stay in many general psychiatry inpatient units is five to seven days.) Group therapy was no longer about systematically developing relational skills because there was not enough time. More and more inpatient stays focused on assessing acute symptoms, modifying drug regimens and providing more individualized therapy targeted at the immediate crisis or circumstance.

Another theme has emerged over the past decade. Recognition has grown that many female inpatients have histories of interpersonal violence. Although psychiatry

was slow to respond, it is not surprising that female inpatient units are overrepresented by women with such experiences. It is well recognized that trauma can result in pervasive, long-term impacts on mental health that do not fit neatly into a single *DSM-IV* category. Relational problems, emotion regulation issues and a fundamental mistrust of others are common. Indeed, women with histories of childhood interpersonal violence often reflect the most complex clinical presentations: They are not stable longitudinally; they respond poorly to drug therapies; they are heavy users of mental health services with limited success and they require long-term multi-modal, highly specialized treatments. Extended time in specific outpatient trauma programs interspersed with short inpatient stays for crisis intervention is typical.

Short average lengths of stay and increased recognition of the relational problems that can arise from histories of trauma have led some to argue for gender-segregated inpatient units. They posit that women will feel safer and will not be triggered as much, especially by men who may have aggressive outbursts or inappropriate social behaviors. Female-only units would provide a therapeutic environment where women could progress on their journey towards wellness.

But before we set out on this course, we need to carefully examine the evidence that this change in policy would actually achieve better care for female inpatients. Some data suggest that men and women do better with different types of psychotherapy, which supports the notion of gender-specific group therapies. Research about adult sequelae of child abuse does suggest that men and women interpret and react to these experiences differently and thus likely need different therapeutic targets. There is growing belief that treatment programs, especially the psychotherapy-based components, may need to consider gender as a determinant of content. In the past, many trauma-related resources had a female bias, almost by default. In terms of childhood interpersonal violence, men are often reluctant to disclose such experiences. More needs to be done to address gender differences in therapies

Editorials do not necessarily reflect the views of CAMH. We welcome submissions from our readers. For information, contact the Editor, *CrossCurrents*, 33 Russell St., Toronto, Ontario M5S 2S1, tel 416 595-6714, e-mail hema_zbogor@camh.net

targeted at the profound consequences that can result from interpersonal violence. However, that does not necessarily translate to segregated inpatient units.

Indeed, many questions remain. Will these female-only units be just for women who have experienced violence? Although trauma is overrepresented in the psychiatric population, not all inpatients have experienced it. Will women without trauma feel as comfortable if the main therapeutic focus is trauma? Antepartum and postpartum inpatient units are gender-specific services for women, but are they truly gender-sensitive? I would say they are not.

Moreover, is it true that an all-female unit would be more therapeutic or safer from triggers that evoke powerful emotional and physical reactions? Could not the behaviour of other female inpatients also serve as triggers? Would all staff have to be female? For women with histories of violence, the core issues are often around control, trust and interpersonal relationships. These issues can lead to misinterpretation, ambivalence and conflict from any interaction, regardless of gender. Past family dynamics may have involved conflicts with mothers, such that an all-female staff will not ensure feelings of safety, validation and trustworthiness. Moreover, agency policies, processes regarding admission and discharge, rules of who can be admitted and how long patients can stay may not be totally responsive to the needs of women with trauma.

The historical reasons for desegregation made therapeutic sense at the time and prompted profound improvements in inpatient psychiatric care. More recent developments in psychiatric service delivery have raised questions about the current validity of those reasons. Before we embark on a path to re-segregate, we need to be sure we are fully aware and prepared to deal with all the implications.

Kathy Hegadoren is a professor in the Faculty of Nursing at the University of Alberta and a Canada Research Chair in Stress Disorders in Women.

CANADA

Society of Behavioral Medicine 30th Annual Meeting

April 22–25, Montreal, Quebec
Contact: Society of Behavioral Medicine,
555 East Wells St., Ste. 1100, Milwaukee,
WI 53202-3823 USA
tel 414 918-3156
fax 414 276-3349
e-mail info@sbm.org
www.sbm.org/meeting/2009/

Embracing the Future of Addictions Treatment: An International Conference on Addictions and Mental Health

April 23–24, Toronto, Ontario
Contact: Salvation Army Toronto Harbour Light
tel 416 321-3910, ext. 283
e-mail tiscott@harbourlight.org
www.harbourlight.org/info/teaching-conference

31st Annual Substance Abuse Librarians and Information Specialists Conference

May 5–8, Halifax, Nova Scotia
Contact: SALIS, P.O. Box 9513, Berkeley, CA
94709-0513 USA
tel 902 424-7214
e-mail Ruth.Hart@gov.ns.ca
http://salis.org/conference/conference.html

2nd Annual Canadian Network for Innovation in Education International Conference 2009

May 10–13, Ottawa, Ontario
Contact: Crystal Mohr, Canadian Healthcare
Association, 17 York St., Ottawa, ON K1N 9J6
tel 613 241-8005, ext. 226
fax 613 241-5055
e-mail cmohr@cha.ca
www.cha.ca

Risky Business: From Prevention to Advanced Trauma Care

May 14–15, Montreal, Quebec
Contact: Christianne Levesque-Quintal or
Josee Maurice, McGill University Health
Centre, Trauma Program, 1650 Cedar Ave.,
Montreal, QC H3G 1A4
tel 514 934-1934, ext. 44412 or 48420
fax 514 934-8215
e-mail trauma.program@muhc.mcgill.ca
www.medicine.mcgill.ca/traumaprogram/

10th National Conference on Collaborative Mental Health Care

May 28–30, Hamilton, Ontario
tel 905 667-4861
e-mail sari.acherman@hamiltonfht.ca
www.shared-care.ca

Spirit Heals Conference

May 29–31, Victoria, British Columbia
e-mail info@spiritheals.ca
www.crish.org

Canadian Psychological Association Annual Convention

June 11–13, Montreal, Quebec
Contact: CPA, 141 Laurier Ave. W., Ste. 702,
Ottawa, ON K1P 5J3
tel 613 237-2144, ext. 323
toll free 1 888 472-0657
fax 613 237-1674
e-mail convention@cpa.ca
www.cpa.ca/convention/

50th Annual Institute on Addiction Studies

July 12–16, Barrie, Ontario
Contact: Addiction Studies Forum, Box 322,
Virgil, ON L0S 1T0
toll-free tel 1 866 278-3568
toll-free fax 1 888 898-8033
e-mail info@addictionstudies.ca
www.addictionstudies.ca

117th Annual Convention of the American Psychological Association

August 6–9, Toronto, Ontario
Contact: APA, 750 First Street, N.E.,
Washington, DC 20002-4242 USA
tel 202-336-5500
e-mail convention@apa.org
www.apa.org/convention09/

59th Annual Conference of the Canadian Psychiatric Association

August 27–30, St. John's, Newfoundland
Contact: CPA, 141 Laurier Ave. W., Ste. 701,
Ottawa, ON K1P 5J3
tel 613 234-2815
fax 613 234-9857
e-mail conference@cpa-apc.org
www.cpa-apc.org

Annual Meeting of the International Society of Addiction Medicine

September 23–27, Calgary, Alberta
e-mail office@isamweb.com
www.isamweb.org

6th National Conference on Tobacco or Health

November 1–4, Montreal, Quebec
Contact: Canadian Council for Tobacco Control,
192 Bank St., Ottawa, ON K2P 1W8
tel 613 567-3050
fax 613 567-2730
e-mail conference@cctc.ca
www.ncth.ca

Issues of Substance Conference

November 15–18, Halifax, Nova Scotia
e-mail ios@ccsa.ca
www.issuesofsubstance.ca

UNITED STATES

Society for Social Work Leadership in Health Care 44th Annual Conference

April 22–25, New Orleans, Louisiana
Contact: SSWLHC, 100 N. 20th St., 4th fl.,
Philadelphia, PA 19103
toll-free tel 1 866 237-9542
e-mail lgroff@fernley.com
www.sswlhc.org/html/conference.php

2009 Conference of the European Opiate Addiction Treatment Association and the American Association for the Treatment of Opioid Dependence

April 25–29, New York City, New York
www.europad.org

15th Annual Mayo Clinic Nicotine Dependence Conference: "A Focus on Mental Illness and Substance Abuse"

April 28–30, Rochester, Minnesota
e-mail cme@mayo.edu
www.mayo.edu/pmts/mc8000-
mc8099/mc8000-60.pdf

American Society of Addiction Medicine 40th Annual Conference

April 30–May 3, New Orleans, Louisiana
Contact: ASAM, 4601 N. Park Ave., Upper
Arcade, Ste. 101, Chevy Chase, MD 20815
tel 301 656-3920
fax 301 656-3815
e-mail@asam.org
www.asam.org/AnnualMeeting.html

2009 National Association of Addiction Treatment Providers Annual Addiction Treatment Leadership Conference

May 16–19, West Palm Beach, Florida
Contact: NAATP, 313 W. Liberty St., Ste. 129,
Lancaster, PA 17603-2748
tel 717 392-8480
fax 717 392-8481
e-mail rhunsicker@naatp.org
www.naatp.org/conferences/annualconference.php

American Psychiatric Association 162nd Annual Meeting

May 16–21, San Francisco, California
Contact: APA, Office to Coordinate Annual
Meetings, 1400 K St., N.W.,
Washington, DC 20005
toll-free tel 888 357-7924
fax 202 789-8882
e-mail apa@psych.org
www.psych.org

Association for Psychological Science 21st Annual Convention

May 21–24, San Francisco, California
Contact: APS, 1133 15th St. N.W., Ste. 1000,
Washington, DC 20005
tel 202 293-9300
fax 202 293-9350
www.psychologicalscience.org/convention

International Child and Youth Care Conference

May 26–29, Fort Lauderdale, Florida
Contact: Juan Carlos Sánchez, conference
manager, P.O. Box 11858,
Fort Lauderdale, FL 33339
tel 954 397-2830
fax 954 366-1540
e-mail jsanchez@iccycc2009.com
www.iccycc2009.com

National Eating Disorder Conference: Advanced Treatments for Eating Disorders

June 4–7, Las Vegas, Nevada
Contact: Ben Franklin Institute, P.O. Box 7128,
Cave Creek, AZ 85327
tel 480 585-5247
fax 480 585-3226
e-mail info@bfisummit.com
www.bfisummit.com

Research Society on Alcoholism Annual Scientific Meeting

June 20–24, San Diego, California
Contact: RSoA, 7801 North Lamar Blvd.,
Ste. D-89, Austin, TX 78752-1038
tel 512 454-0022
fax 512 454-0812
e-mail debbyrsa@sbcglobal.net
www.rsoa.org/2009meet-indexAbs.htm

College on Problems of Drug Dependence 71st Annual Meeting

June 20–25, Reno, Nevada
e-mail ebgeiler@temple.edu
www.cpdd.vcu.edu/

ABROAD

Society for Research on Nicotine and Tobacco 15th Annual Meeting

April 27–30, Dublin, Ireland
Contact: SRNT, 2810 Crossroads Dr.,
Ste. 3800, Madison, WI 53718 USA
tel 608 443-2462
fax 608 443-2474 or 608 443-2478
e-mail meetings@srnt.org
www.srnt.org/meeting/future/future.html

12th European Federation of Therapeutic Communities Conference

June 2–5, The Hague, The Netherlands
e-mail eftcinfo@parnassiabavogroep.nl
www.eftc-bepartofthesolution.eu

16th Congress of the International Society for the Psychological Treatments of the Schizophrenias and Other Psychoses

June 15–19, Copenhagen, Denmark
Contact: International Conference Services,
P.O. Box 41, Strandvejen 171, DK-2900
Hellerup, Copenhagen, Denmark
tel 47 2310 3777
e-mail ISPS2009@ics.dk
www.isps2009.ics.dk

World Psychiatric Association 2nd Thematic Conference on Legal and Forensic Psychiatry

June 16–20, Madrid, Spain
e-mail forensicpsychiatry2009@gmail.com
www.worldpsychiatricassociation.org

World Mental Health Congress

September 2–6, Athens, Greece
Contact: ERA Ltd, 17 Asklipiou Str.,
106 80 Athens, Greece
tel 30 210 3634 944
fax 30 210 3631690
e-mail info@era.gr
www.wmhc2009.com

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