TRAUMA MATTERS

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TRAUMA CENTER OF EXCELLENCE EXPANSION

To further the work of its Trauma Initiative, the Western Connecticut Mental Health Network (WCMHN) is capitalizing on the experience gained by their *Trauma Center of Excellence* located in Torrington and are in the process of expanding this knowledge base to the two other locations in its region. WCMHN is a part of the Connecticut Department of Mental Health and Addition Services (DMHAS) and provides services and exercises oversight of affiliate agencies throughout DMHAS Region 5 which includes Greater Waterbury Mental Health Authority (GWMHA); Greater Danbury Mental Health Authority (GDMHA) and their affiliates. With continued funding through The Center for Substance Abuse Treatment (CSAT), expansion of Trauma Informed Systems of Care developed at the *Trauma Center of Excellence* is now in progress in the Waterbury and Danbury areas. Technical assistance for the continuation of this project is being provided by national trauma expert, Dr. Roger Fallot, from Community Connections in Washington, D.C. He replicated his full day workshop and Eileen Russo, MA, has provided consultation and training to both agencies and their affiliates.

According to Dr. Fallot, "trauma-informed approaches are built on what we know about common responses to physical, sexual, and emotional abuse. For instance, because trauma survivors have been particularly sensitized to potential signs of danger, ensuring emotional and physical safety in the service context is a top priority. Because trauma so often involves the abuse of power in relationships that were supposed to be caring ones, the trauma-informed system prioritizes collaboration, shared decision-making and clear roles and boundaries in the services relationship. Because traumatic stress is part of so many individuals' lives, including many providers', and because vicarious or secondary traumatization is a real risk, a trauma-informed system also emphasizes the safety and support needs of service providers".

Reliable evidence currently exists suggesting that individuals who have experienced trauma may be re-traumatized by the very service systems from which they seek assistance. Five basic principles are being highlighted as areas for focus when establishing a Trauma Informed Service System. Dr. Fallot cites these core principles as:

- Safety: Ensuring physical and emotional safety.
- Trustworthiness: Maximizing trustworthiness, making tasks clear and maintaining appropriate boundaries.
- Choice: Prioritizing consumer choice and control.
- Collaboration: Maximizing collaboration and sharing of power with consumers.
- Empowerment: Prioritizing consumer empowerment and skill building.

Each of these principles will be expanded upon in upcoming issues of Trauma Matters. The Connecticut Department of Mental Health and Addiction Services is committed to further expansion of the Trauma Initiative and Commissioner Thomas Kirk, PhD. continues to share his vision and support of the project. Both he and Deputy Commissioner Peter Rockholtz were in attendance at the recent events at GWMHA and GDMHA. An evaluation is currently underway to assess the progress and changes that have occurred as a result of this Initiative. For more information on the Trauma Center of Excellence, contact Colette Anderson, Director of Northwest Mental Health Authority at 860-496-3724 or send an e-mail to colette.anderson@po.state.ct.us.

Submitted by
Colette Anderson, Director
Northwest Mental Health Authority

GAY, LESBIAN AND BISEXUAL SURVIVORS OF TRAUMA

In June, we celebrated the Gay Rights movement, let's not forget the issues of gay, lesbian, bisexual and transgender people who experience trauma. This article highlights some of the clinical issues and how clinicians can be GLBT-affirming in providing trauma-informed care. The next issue of this newsletter will pay special attention to understanding the needs of transgender survivors. Many GLBT clients have had negative experiences when we seek therapy. We have heard hurtful messages and some professionals have tried to change us.

So, imagine you have been the victim of verbal, physical or sexual abuse, which was traumatizing. Once you were willing and able to communicate about it, you get an appointment with a mental health professional. As you start to share about yourself and what has happened you get the feeling that either you are not liked or misunderstood. This "helping process" can start to feel re-traumatizing and instead of facilitating recovery, it can make the process more protracted.

Several studies have shown that GLBT people are at increased risk for depression, anxiety and substance use disorders (Cochran and Mays, 2000; Gilman, et al., 2001). GLBT people living with a mental illness are more vulnerable, underserved and sometimes invisible. GLBT victims fear the consequences of reporting incidents. They want to "move on" from the incident. And often they may start to believe that the incident stemmed from poor personal judgment.

GLBT youth of color face additional challenges. Unlike racial stereotypes that family and one's ethnic community can positively reframe, many ethnic minority communities reinforce negative cultural perceptions of homosexuality and bisexuality. Up to 46% of GLBT youth of color report experiencing physical violence related to their sexual orientation. (GLSEN, 2004) They lack positive role models, may take sexual risks and/or attempt suicide as a means to cope and escape. How can we be GLBT-affirming in our work with trauma survivors?

- Know your own GLBT-competency and level of comfort. Seek supervision and consider referral if too much is in the way.
- Be frank about your own sexual orientation. GLBT people often feel more comfortable with "out" GLBT therapists, but genuine, affirming messages can facilitate trusting therapeutic alliance
- Be sensitive to language. For example – use the phrase sexual orientation not preference. A preference is something you prefer vs. orientation is constant and unchanging.
- Give yourself permission not to know all about GLBT issues and make a personal commitment to expand that knowledge out of session.

Submitted by
Dr. Richard Stillson
Director of Psychology, Cedarcrest Hospital

Additional Resources for Working with GLBT Survivors:

LGBT Survivors of Sexual Violence
Carissa or Anja @ (203) 624-4576

Resources finder for Torture Victims, Asylum-Seekers & Refugees
http://kspope.com/torvic/torture.php

Inpatient substance abuse treatment for LGB people
PRIDE Institute www.pride-institute.com
(800) 54-PRIDE

GLBT Affirming Therapists – CT state-wide list
GLBT Task Force of the CT Psychological Association
Richard Stillson, Ph.D. (860) 666-7645

Women's Center for Psychotherapy
(860) 724-5542

CONN Bi Nation
(860) 523-4450

Gay Men's Support Group
Wednesdays @ Wheeler Clinic
Peter Pappollo (860) 793-3500

References

- Cochran, S.D. & Mays, V.M. (2000). Lifetime prevalence of suicidal symptoms and affective disorders among men reporting same-sex partners: results from the NHANES III. Am J Pub Health. 90:573-578.
- Gay, Lesbian and Straight Education Network.(2004*). The 2003 National School Climate Survey: The School Related Experiences of Our Nations Gay, Lesbian, Bisexual and Transgender Youth*. NY: GLSEN.
- Gilman, S.E., Cochran, S.D., Mays, V.M., et al. (2001). Risk of psychiatric disorders among individuals reporting same-gender sexual partners in the National Comorbidity Survey. Am J Pub Health. 91:933-939.

The Effects of Systemic Oppression on Women's Lives

On September 13 and 14, 2006, The Connecticut Women's Consortium will present a two-day training and discussion on poverty, sexism, class, trauma and violence. The training will be at the Omni Hotel New Haven @ Yale and will feature Stephanie Covington, PhD, and Kenneth Hardy, PhD. Dr. Covington is an internationally renowned clinician, trainer and speaker on women's issues including violence, trauma, addictions and providing gender-responsive treatment. Dr. Hardy is an internationally renowned MFT clinician, trainer, and speaker who has made significant contributions toward challenging the therapy field to think critically about the hidden but significant connections that often exist between trauma and issues of oppression for people of color. The training will cover levels and structure of violence, the connection between violence, abuse, trauma, gender differences and voiclessness and the dynamics of oppression. In addition, there will be an opportunity for everyone to attend workshops by Dr. Covington and Dr. Hardy that will focus on interpersonal violence, trauma of stigmatization, systemic re-traumatization issues, gender issues, race, class, poverty, and systemic oppression of women and people of color. The goal of the training is to improve the ability of direct staff to deliver services to women that are non-oppressive, trauma-informed, and gender specific and to begin a dialogue that will erase systemic oppression of women, men and children. For more information, go to www.womensconsortium.org or call (203) 498-4184 ext. 30 or ext. 33.

Featured Resource

Healing Trauma: The Power of Group Treatment for People With Intellectual Disabilities
Nancy J. Razza and Daniel J. Tomasulo American Psychological Association, 2005

Shortly into its pages, Healing Trauma states, "Until fairly recently, people with intellectual disabilities were routinely denied psychotherapy. Clinicians assumed people with mental retardation did not have the requisite abilities to engage in the therapeutic process". (p 12) This assumption was made in the face of startling statistics, 83% of women and 32% of men with intellectual disabilities have been sexually abused (Wisconsin Council on Developmental Disabilities, 1991).

Healing Trauma is a reader friendly volume that provides a good (and quick) review of the literature and teaching modalities provided to those with intellectual disabilities up until the recent past. The rest of the book is devoted to describing the Interactive-Behavioral Therapy (IBT) model of group psychotherapy. The model's theoretical base is from the work of J.L. Moreno (psychodrama) which to put it simply, involves the whole person, not just thinking and talking. "For those with cognitive impairment traditional "talk" therapies limits engagement in the therapeutic process. However, by engaging the individual through behavioral and emotional means as well we are increasing the individual's opportunity to do meaningful therapeutic work" (p 34).

The IBT model has an evidence base that tested efficacy (Blaine, 1993), emergence of therapeutic factors, (Keller, 1993), effectiveness with chronic mental illness (Daniels, 1998) and application to bereavement (Carlin, 1998). All show promising results. Unlike other evidence based treatment approaches, IBT is not curriculum driven and encourages member to member interaction rather than a teacher-student approach. While not curriculum based, each session does have a structure that consists of 4 components:

1. Orientation (rule review/reminders/housekeeping/cognitive networking)
2. Warm-up and Sharing
3. Enactment
4. Affirmation

Healing Trauma also describes in detail the application of IBT to offenders (who are usually victims/survivors also), which is an area that is often cloaked in mystery and fear. IBT is not limited to group work. Chapter 8 outlines ways to engage those with intellectual disabilities in individual therapy.

In summary, Healing Trauma offers to those providing trauma services another tool for the clinical tool box. And for the other Yalom fans out there, it was very satisfying to see his therapeutic factors being woven into the model and referenced throughout the book.

Eileen M. Russo
CT Renaissance

Summer Safety Tips

Summer is in full swing and there are thing you can do to assure you will continue to enjoy the HOT weather and still be safe. Warm weather means activities and fun under the sun! Whether you love putting on shorts and feeling the warm outdoors, or find it hot and sticky, everyone must be careful not to let a heat-related illness spoil the day.

- **Dress for the heat.** Wear lightweight, light-colored clothing. Light colors will reflect away some of the sun's energy. It is also a good idea to wear hats or to use an umbrella.
- **Drink water.** Carry water or juice with you and drink continuously even if you do not feel thirsty. Avoid alcohol and caffeine, which dehydrate the body.
- **Eat small meals and eat more often.** Avoid foods that are high in protein which increase metabolic heat.
- **Avoid using salt tablets unless directed to do so by a physician.**
- **Slow down.** Avoid strenuous activity. If you must do strenuous activity, do it during the coolest part of the day, which is usually in the morning between 4:00 a.m. and 7:00 a.m.
- **Stay indoors when possible** and use air conditioning and regular or ceiling fans to cool your house/office.
- **Take regular breaks** when engaged in physical activity on warm days. Take time out to find a cool place. If you recognize that you, or someone else, is showing the signs of a heat-related illness, stop activity and find a cool place. Remember, have fun, but stay cool!
- For more information on staying safe during boating, swimming and other outdoor activities, go to www.redcross.org/services

Getting into Trauma Matters

- You can access an electronic version of the "*Trauma Matters"* Newsletter at www.traumamatters.org; www.dmhas.state.ct.us; or www.womensconsortium.org
- Do you want to be placed on our mailing list or is there an event or topic you would like covered in this newsletter? Please call "*Trauma Matters"* editor Carol Huckaby at 203.498.4184, x25 or e-mail her at chuckaby@womensconsortium.org.

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