

TRAUMA MATTERS

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Carol Huckaby, Editor

USING TRAUMA THEORY TO DESIGN A SERVICE SYSTEM

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On March 23, the Northwest Mental Health Authority (NWMHA) hosted a Strategic Planning meeting with representatives from all of its treatment programs and affiliate agencies. There was excitement in the room as Dr. Roger Fallot from Community Connections in Washington, D.C., was introduced as the day's facilitator. Dr. Fallot, with funding from CSAT is serving as the CT Trauma Center of Excellence's national consultant.

The day began with opening remarks from DMHAS Commissioner Thomas Kirk, Ph.D. who shared his vision and support for the development of a self-assessment protocol and work plan that will guide the NWMHA Service System's evolution into a Trauma Informed System of Care.

Dr. Fallot captivated the audience as he described the characteristics of trauma-informed services as being:

- Hospitable and engaging for survivors
- Minimize re-victimization
- Facilitates recovery and empowerment
- Incorporates knowledge about trauma—prevalence, impact and recovery in all aspects of service delivery

The day's work was done in workgroups based on the following service types:

- Case Management, Vocational, Residential
- Clinical Services
- Young Adult Services and
- Substance Abuse Treatment

Work group participants included support staff, nurses, social workers, mental health workers, physicians, substance abuse counselors and administrators, as well as representation from the Northwest Regional Mental Health Board. The groups worked on a self-assessment and planning protocol which involved looking at the changes needed at both the administrative and service level as well as the trauma training and educational needs of staff. A process commenced to review formal service policies and formal and informal service procedures. The day ended with a prioritization of the next steps needed in order to alter the service delivery system.

Dr. Fallot will be providing ongoing support to the Strategic Planning Committee at NWMHA and the DMHAS Advisory Committee as they prioritize specific objectives and develop their work plan. The level of enthusiasm and support for the integration of knowledge about trauma and violence pervade all aspects of the Service System.

Featured Resource

Title: Using Trauma Theory to Design Service Systems
Maxine Harris, PhD and Roger Fallot, PhD, editors
New Directions for Mental Health Services, No. 89, 2001
ISBN# 0-7879-1438-X

Overview: This is a slim (97 pages) easy to read plain language volume. The book is separated into chapters that address different areas of trauma informed care such as screening and assessment, inpatient services, housing, addiction services, case management and care of the clinician. Once you read the first chapter for an overview, each subsequent chapter can stand alone. This means the reader can easily focus on the area(s) of concern and interest. This book does not focus on any particular trauma model but rather provides some over arching principles for agencies who are striving to become trauma informed.

HEALING AN AGENCY WHEN TRAGEDY OCCURS

When unimaginable tragedy occurs at an agency such as the suicide of a client, it is important to apply good trauma principles to the staff as well as the clients. First and foremost this means a timely, empathic response, which validates everyone's experience. No one can know the totality of experience that both groups have around suicide and death, including the wide range of ways that death is acknowledged (or not) by past experience within families and other community supports.

When a client commits suicide it becomes the responsibility of the treatment family to respond to all of its members, interact with investigative personnel, calm and comfort clients, each other and also meet with family members. Just like any sudden death, there are many unanswered questions that will be agonized over for months and months if not years. Additionally, there are immediate concerns such as how to make it through the night as well as longer term planning which include healing rituals and making extended treatment and option for all of the clients as well as the staff. Many times the simplest of actions can become the most comforting: a meal shared together, quiet conversations with others about shared memories of the deceased, playing meaningful music, or reading a poem or scripture.

Having gone through the experience on an inpatient unit one of the most immediate considerations was sharing a meal together even though initially, no one wanted to eat. Looking back, that became one of the most normalizing experiences during a night that was a nightmare. Staff was allowed to stay as long as they needed to. Debriefing meetings with the CISM team were held simultaneously for staff as well as clients. Some staff came to work even though they were off duty to grieve with their work family. The debriefing sessions initially had mixed reviews, however looking back, most of the staff that participated in the sessions seemed to have an easier time and also had group members that they could connect with in the days ahead. Other co-workers from across the agency came to help out in ways that are too numerous to mention, but entirely supportive and surprising. As a way to deal with the initial terror that clients expressed, cots were brought in to allow large groups of clients to sleep together for comfort, although at bedtime almost all of them chose to sleep in their own beds.

The next day, some staff chose not to come to work for individual reasons, which left other staff and clients feeling abandoned. Again, it is important to mention that just as no assumptions can be made about clients' experiences regarding suicide and death, the same is true of co-workers. No one knows whose family might have been affected by suicide or who among the group may have contemplated or attempted suicide in his or her own lives. These are not the typical conversations we have with co-workers, and yet so important to know about the clients we work with. This is one of those unexplainable gaps that complicate healing for staff.

In terms of healing rituals, the clients and staff created a memorial on a bulletin board with messages, poems, pictures and butterflies in a room that was the main treatment area. One of the staff members bought helium balloons that the clients wrote sentiments and messages on and then they went outside as a group and released the balloons to float up into the sky. We purchased purple butterfly bushes that the group planted with a small ceremony and music chosen by the clients. A somewhat slightly more controversial decision was made upon request of the clients to bring in a priest to bless the area in order to restore a feeling of peace. What is done to mark the event is not as important as the meaning attached to it. If the individuals find healing and meaning in the ritual, my guess is that it will be beneficial.

This is the club that no agency ever wants to belong to. No one is ever prepared for a suicide and no one wants to think about it in advance. There is no going back to business as usual. What was normal is in the past. The staff and clients will be forever changed as a result. We can however, heal, become more sensitive individuals, learn more about the etiology of suicide and take steps to improve awareness and prevention practices wherever possible.

Submitted by
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Cultural Trauma Definition

Trauma is the by-product of any event or circumstance that emotionally, psychologically, and/or physically devastates one's being while it simultaneously overwhelms, destroys, or neutralizes one's strategies for coping. The emotional impact of trauma is generally sustained, intense, and pervasive. There are multiple sources and manifestations of trauma. Thus, a broad view of trauma is necessary. Socio-cultural oppression is a sustained, intensive, and lifelong experience; its effects are often persistent and contribute significantly to a variety of *hidden wounds of trauma*. These are the invisible but powerful effects of trauma that are devastating but have been disconnected from the original traumatizing event.

Cultural Issues and Trauma

- Culture is a broad based multidimensional concept that shapes our attitudes, beliefs, and behaviors.
- Culture, rather than the singular simplistic concept that many of us often consider it, is complex, multi-layered and is comprised of numerous dimensions. Race, ethnicity, class, religion, gender, sexual orientations are but a few examples of dimensions of culture that profoundly impact on our lives.

The relationship that culture has to trauma is as follows:

- It can be a source of trauma as in the case of gender oppression and sexism; and/or
- It can have a significant impact on what one considers traumatic, and the specific strategies that one might employ to facilitate coping and recovery.

Culture as a Source of Trauma

- Culture obviously does not cause trauma. However, depending on what one's background is regarding certain dimensions of culture, oppression, and ultimately trauma can be an integral component of one's cultural background.
- Any individual who has membership in a group that is marginalized (e.g., people of color, the poor, women, gay and lesbians, etc) in society is predisposed to experiences of trauma *associated with culture*. Thus, whether trauma is associated with culture is ultimately determined by whether or not a particular dimension of culture that characterizes one's background locates them in a social position of subjugation or privilege.

Cultural Issue in Trauma

- Just as culture can be implicated as a source of trauma, it can also be a powerful system for individuals experiencing trauma.
- Culture should virtually always be an important consideration when attempting to understand the impact of trauma on the life of an individual or group. Often the meaning or frame of reference that one uses to understand the anatomy of trauma is sharply informed by culture (and its various dimensions).
- One's response to trauma, coping mechanisms employed or decried, and definitions of resiliency are all sanctioned by culture in one way or another.
- There are several salient factors associated with cultural issues in trauma. Many of these factors constitute major organizing principles—that is, basic constructs that shape our beliefs and actions in times of trauma. The following is an illustrative list of common culturally based organizing principles that often shape one's response and efforts to cope with trauma:
 - Faith and spirituality;
 - Locus of Control;
 - Tolerance for pain, suffering, and discomfort;
 - Coping strategies employed;
 - Legacies and loyalties;
 - The type of help sought, and from whom, when, etc.;
 - Recovery-response time.

Cultural Issues in Addressing Trauma

1. It is essential that we expand our notions of trauma to include the hidden effects of trauma associated with culture.
2. It is seldom a question as whether culture plays a role in trauma BUT how. Thus, it is imperative to disentangle and comprehend the ways in which culture is often inextricably tied to experiences with trauma---either as a source of trauma and/or as a frame of reference.
3. It is important to remain cognizant that for those who are traumatized (by virtue of a situational circumstance) and who also hold membership in groups that are socially marginalized are often doubly traumatized. Our intervention efforts must acknowledge both.
4. It is important to openly and extensively explore the multitudinous ways in which the response to a traumatizing event, the coping strategies employed, as well as the meaning system that is used "to make sense out of what happened" are all shaped by the nuances of culture.

SAFETY TIPS

Working While Ill Ups Heart Attack Risk

People who schlep into the office even when battling a cold or other illness are not only putting their co-workers at risk for infection, they're likely raising their own heart-attack risk. A study in the January *American Journal of Public Health*¹ of more than 5,000 British civil servants with no history of heart problems found that those who took no sick days but worked while ill were twice as likely to suffer a serious coronary event as their co-workers who took sick leave. The risk for heart problems was highest among those who rated their own health as average or lower and were suffering from some psychological distress. The study's authors hypothesized that people who fail to call in sick might face a higher heart attack risk because of ignoring health problems and the added stress of trying to work while ill.

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“NO MORE SECRETS” VIDEO

In October 2000, the Connecticut Department of Mental Health & Addiction Services (DMHAS) produced the video entitled “Trauma: No More Secrets”. This is a documentary film based on the lives of four women who have experienced trauma and were introduced to the behavioral health system through their addiction and mental health issues. These inspiring women offer a frank discussion of their personal histories of childhood and adult trauma, their means of coping, their experience with substance abuse and mental health treatment providers, and their progress in recovery from a place of despair to one of hope. This moving film, along with a panel discussion with two of the women featured, has become a key element in the training of clinicians and case managers in Connecticut and other states.

“The Trauma: No More Secrets” video and guidebook are now available upon request from the CT Women’s Consortium for a fee of \$16.50 to cover reproduction and mailing costs. For more information please contact Carol Huckaby @ 203-498-4184, Ext. 25.

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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