

# Trauma Matters

Summer 2022

A quarterly publication dedicated to the dissemination of information on trauma and best-practices in trauma-informed care.

## Virtual Counseling/Psychotherapy:

Experiences from *Trauma Matters* Readers

by Steve Bistran, MA

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A PDF version of this publication with a full list of references is available for download at:

[www.womensconsortium.org](http://www.womensconsortium.org)



*The following represents the experiential opinions of a relatively small, non-random sample of individuals involved with virtual counseling/psychotherapy. It is not intended to represent an overall assessment of this practice.*

The Winter 2021 edition of *Trauma Matters* included an article entitled “Virtual Counseling/Psychotherapy,” which provided an overview of the subject. The article included definitions, a brief history, advantages and disadvantages of the practice, and some very brief outcome results. At the end of the article, readers who provided and/or received virtual counseling were invited to share some of their experiences and thoughts in a number of relevant areas.

Twenty-six individuals responded to our invitation. Of these respondents, 25 indicated that they were providers, 8 of the 25 indicated that they were also recipients, and one respondent did not specify. What follows is a summary of those responses, along with some of the recommendations these individuals suggested.

When asked to describe the shift from in-person to virtual counseling, respondents cited a range of experiences. The most frequently cited experiences included unexpected eye strain, fatigue, tiredness, and physical strain as providers expended

energy deciphering facial expressions, movements, and voice tones on screen.

The importance of the provider’s ability to adapt to the change was also cited; many providers indicated initially feeling uncomfortable, disconnected, and somewhat overwhelmed in this unfamiliar environment. Respondents advised that providers beginning virtual contacts with patients should expect to experience an adaptation period for both the client and themselves. Other comments included:

Finding the change “all-consuming, as your home is your office and vice versa and [I] have needed to set firm boundaries and practice better self-care.”

“It is harder to work with dysregulated clients and I hesitate to ‘push’ clients to do therapeutic work at times due to not being there.”

“Some clients have difficulty recognizing the need for therapeutic space despite discussing it with them... and once in a while in inappropriate places (while driving, at the store, with others in the room, etc.) and need to be rescheduled.”

Nevertheless, with time, practice, and patience, most respondents evolved a positive view of working virtually with clients:

“It’s been extremely helpful and I don’t know how I or my clients would do without it.”

“I’ve been virtual for years and love it!!!”

“It certainly reduces cancellations.”

“Surprisingly good.”

Inquiring about technical difficulties during virtual meetings resulted in the most and lengthiest comments. While several respondents replied with a simple “No” or “None,” the majority cited slow lag times, occasional and sometimes frequent buffering, pixilating screens, pictures that freeze while audio continues, distorted

sound, sound out of sync with picture, unreliable internet and the need to upgrade equipment, and losing connections altogether.

When asked if it was easy to develop a trusting relationship via virtual contact, the responses were overwhelmingly “Yes!” Comments included:

“Yes, it seems to have been ok.”

“Yes...feels like a home visit...warm easy connection.”

“I thought it would be harder than it was actually.”

“Surprisingly, yes.”

However, not all clients reacted the same to the virtual experience, and respondents highlighted that providers will need to take this into consideration:

“With younger clients (45 and younger), yes [it was easy to develop a trusting relationship]... older clients, it’s variable... younger than 15 it is also hard... kids need to be in your presence.”

When asked to describe the quality of the therapeutic relationship they were able to develop virtually with clients, providers were consistently positive:

“I feel I have been able to develop quality therapeutic relationships with patience, although it has taken a bit longer and a bit more work on my part.”

“Easier to develop rapport.”

“It’s a little more challenging to establish rapport, but once you get going it’s fine.”

“I truly believe [the relationships] are just as strong as they were in person...some relationships I think are even stronger due to some clients having a lot of fear going into an unfamiliar place and being vulnerable.”

“Same as in office, I have not seen barriers here.”

“Most have been excellent...a year later I realize that some clients I have only met virtually...yet we have a connection.”

Does communicating virtually have any effect on achieving therapeutic goals? Our respondents were mixed in their responses. Eleven providers stated “No clear effect,” while another eleven providers stated “Yes” or “Sometimes,” i.e. there were one, two, or multiple effects on achieving therapeutic goals. Three providers indicated it was “Unclear.” It would seem that providers are split on this issue.

Our respondents had many suggestions they would make to others to enhance the virtual experience:

“Be flexible about boundaries as many are

breached (pets, children, and spouses may saunter through a client’s space, or clients may choose to meet you in their car or laundry room to achieve some privacy.)”

“Having a good platform to use makes all the difference.”

“For new clients, I have prefaced the expectations for telehealth to ensure a smooth experience.”

“[The importance of] training for counselors to get good at it.”

“Request clients always have their device stationary and in a position that shows their whole face straight on (not from below or above).”

So what conclusions can we draw from our survey responses?

- Working with clients virtually can evolve into a positive and therapeutic experience, but it is likely to require a “learning curve” for both provider and client.
- Having capable hardware, finding a good platform, and having a reliable Wi-Fi connection are key.
- Provider flexibility and patience will go a long way toward building therapeutic relationships and positive outcomes.
- Sharing both provider and client expectation protocols with clients will likely result in fewer distractions during sessions.

Providers considering initiating teletherapy, who recently started teletherapy, or who are already providing teletherapy services may want to consult links in the following reference section, which includes topics such as how to set up a teletherapy practice, best online platforms for teletherapy, and overall guidelines to practicing teletherapy.

**Many thanks to those *Trauma Matters* readers who responded to our survey and special thanks to Emily Hoyle, previous Editor of *Trauma Matters*, who was responsible for getting the survey online and who compiled the data for analysis and summary.**

*Steve Bistran is a member of the Trauma Matters Editorial Board and has been a member of the Consortium’s “Trauma & Gender” training team. He worked for 26 years in an inpatient behavioral health facility, primarily with individuals coping with severe behavioral diagnoses, before becoming assistant director at the Torrington office of the WCMHN. He has taught students at four colleges and universities and provided clinical supervision to both students and working counselors.*

**Featured Resource:**  
**The Center for Endometriosis Care**  
By Morgan Flanagan-Folcarelli



In the Spring 2022 edition of *Trauma Matters*, Emily Aber interviewed Peter Pruyn, LMHC, on his work with endometriosis, trauma, and EMDR. One resource highlighted during his interview was the [Center for Endometriosis Care](https://www.centerforendo.com), a medical practice in Atlanta, GA that specializes in treating endometriosis.

In addition to providing medical treatment for endometriosis, the Center for Endometriosis Care offers a wealth of resources on the disease. From an overview of endometriosis to dedicated webpages on specific topics such as adolescent endometriosis, adhesions, and infertility, the Center’s website is an excellent place to dive deeper into the complexities of the disease. Whether you are only beginning to learn about endometriosis or are hoping to further your knowledge and find support, the Center’s [resource page](https://www.centerforendo.com/resources) provides links to articles, research, events, and more on a broad range of relevant topics.

Of special note are the sections of resources dedicated to BIPOC and LGBTQIA+ experiences of endometriosis. Here, one can find articles discussing the impacts of racism on endometriosis diagnoses and care, as well as information on the importance of creating non-gendered, inclusive approaches to treatment for trans and nonbinary people living with the disease.

To access this information and the plethora of resources available through the Center’s website, visit:

[www.centerforendo.com/resources](https://www.centerforendo.com/resources).

# Comparative Suffering and Self-Compassion

By Kay Warchol, MA

When I reflect on comparative suffering and self-compassion, this is what comes to mind:

Why complain about gas prices when there are people fleeing from war?

How can you be depressed, there are nurses and doctors working on the front lines during a pandemic?

Eat all your vegetables, there are starving kids that would be grateful for this food.

You have a respectable job, food on the table, and a roof over your head—how can you be sad?

These are just a few of the things that have been stated by those who fall into the trap of comparative suffering. Comparative suffering, as explained by Brené Brown in her podcast *Unlocking Us*, is when “we start to rank our suffering and use it to deny or give ourselves permission to feel” (Brown, 2020). Brown goes on to say that those experiences of suffering do not disappear just because they are deemed inappropriate, or “do not score high enough on the suffering board” (Brown, 2020). The natural tendency to cope with stress by minimizing one’s own issues, or by invalidating those experiences through comparison to others, is a harmful one; it can stop a person from seeking help when they need it.

In his article “Loneliness as a Downstream Concern in a Pandemic (and Post-Pandemic) World,” Daniel R. Malcom, PharmD, Associate Professor of Pharmacy Practice at Sullivan University, writes, “However well-intentioned, the challenge with comparative suffering over the long term is that it devalues and underappreciates the impact of our own emotions and suffering and buries or pushes them away to be dealt with at another time” (Malcom, 2020, pg. 252). Emotions that are left unresolved and unrecognized can lead to bigger issues down the road. Left to fester, we start to develop shame about our emotions; as Brown points out in her podcast, the refrain becomes “other people have it so much worse than me” (Brown, 2020). This shame can start to affect our inclination to seek help, be it from a professional or just from friends. If we feel that our struggles are not worthy and

are less than others, why would we try to talk to someone about our suffering? Why would we imagine they would respond any differently than the negative way we respond to ourselves? As we internalize these ideas, we may become increasingly bitter and resentful of those who are also struggling with the very suffering we deny in ourselves. Without being able to give ourselves empathy, we cut out the ability to be empathetic and compassionate towards others.

So how can we change this narrative? One of the most impactful ways is through self-compassion and self-love. Before we can gain the emotional bandwidth to give



others our loving attention, we must first take care of ourselves. Dr. Kristen Neff, an Associate Professor of Education Psychology at the University of Texas at Austin and a leader in self-compassion research, describes the practice of self-compassion as “being kind and understanding towards oneself in instances of pain or failure rather than being harshly self-critical” (Neff, 2003, pg. 223). Self-compassion responds to our tendencies to invalidate our own experiences by challenging us to think about how we talk to ourselves. Instead of pushing away our emotions, we might instead ask ourselves a new question: how would I treat a friend in the same situation?

The clinicians at Oregon Counseling have a tip about another step towards self-com-

passion, one that can be taken with just the power of the word “and.” By replacing the negating word “but” with the inclusive word “and” in our self-talk, we validate that both things can happen at the same time without ranking which is worse (Oregon Counseling, 2021).

I am upset about the gas prices increasing, and I feel empathy for those being affected by war.

I am having a tough time coping with the changes brought about by COVID-19, and I recognize the hard work and sacrifice of those on the front lines.

Understanding that suffering is not an exclusive experience but rather a spectrum of circumstances helps people respond with empathy rather than self-scrutiny. While it may feel natural to compare our suffering, it is not helpful for long-term positive functioning, for ourselves or others. When we start to pit ourselves against each other, trying to find out who has it worse, we lose sight of the very connections required to navigate our shared and distinct experiences of suffering. No experience is too small for a kind ear to listen and empathize with us. We can better take steps towards healing if we share our lives without the intention of out-suffering—or under-suffering—those around us.

*Kay Warchol, MSW, is a Project Coordinator for The Consortium. They have a social work bachelors from Central Connecticut State University, and a master's in social work from Fordham University. Kay helps collaborate on the Trauma and Gender Initiative (TAG), including the Trauma Services Provider Directory and TAG fidelity scale.*



## Ask the Experts: An Interview with Colette Anderson, LCSW

By Morgan Flanagan-Folcarelli



*Colette Anderson, LCSW, spent over thirty years of her career at the Department of Mental Health and Addiction Services (DMHAS) where she last served as the Chief Executive Officer of Western CT Mental Health Network. Colette has an MSW from the University of Connecticut and maintains her ACSW. As Executive Director, Colette is responsible for the oversight of all programs and funding streams, and for connecting with community providers.*

**MS. FLANAGAN-FOLCARELLI:** Colette, how did you become involved in trauma work, and what led you to your role here as the executive director?

MS. ANDERSON: About 20 years ago, the state Department of Mental Health and Addiction Services (DMHAS) selected four trauma models for the state of Connecticut and for the behavioral health agencies to be trained in. The organization I was working in at the time was Western Connecticut Mental Health Network, and I was running their Torrington site. The model that was selected at that time for our network was called TARGET.

As I learned more about TARGET and the treatment that it provided to the women in our Torrington office, I saw some remarkable transformations happening as the women went through that treatment model. It got me interested in understanding more about these evidence-based

models that we were using in the state of Connecticut.

The state had these “Centers of Excellence.” The Torrington office that I was in applied [to be] a Trauma Center of Excellence. We put in an application based on the work we were doing with the trauma model, and we actually were selected by the state of Connecticut to be the Trauma Center of Excellence. When that happened, there were some resources that became available to us. I met with some folks from the commissioner’s office, and they asked what we thought would benefit our Center of Excellence—and that’s when I asked for some funding to actually do some of the work that we began to do with Roger Fallott.

Roger Fallott came from Community Connections in Washington, DC. He was well known in the trauma field, and he had a small little book that he gave to me that talked about the trauma systems change that was happening around the country. He had interviewed some organizations that had gone through the trauma systems change, and I immediately became very interested in that. So with that funding that we got by being the Center of Excellence, I started this process in Connecticut that brought that trauma-informed systems work into that part of the state. It had such an impact, and I was so happy with how it went, that we brought it into Waterbury and Danbury. Ultimately, I worked with a state committee to bring that out around Connecticut. While I was still working there, we started to do these two-year initiatives on systems change work, and that systems change work has led to my path into being more dedicated to that as a way to look at the mental illness that we’ve been treating all these years.

...

**MS. FLANAGAN-FOLCARELLI:** I know that in the work you do here at the Consortium, when you offer trainings, that trauma-informed spaces are of particular interest to you. What are some of the key pieces of a trauma-informed space?

MS. ANDERSON: In doing the systems change work, there were several elements

that we’re looking at. The elements that we’re looking at for the cultural shift, the primary topics that we talk about are safety for staff and clients, how to develop trustworthiness with individuals that we’re working with, how to include them in making choices, and also, how do you have a collaborative relationship rather than a top-down type of a relationship with the people that you’re treating and teach them to be empowered.

As those elements got fleshed out, some of the really key points that kept coming back in the discussions with the different agencies I was working with centered around safety—safety both for clients and for staff. And having worked in a Joint Commission-accredited agency at the time, I was really starting to think about what could be changed in the environment to make it more safe for those people coming in, but also for the staff who are working there. So some of the implementations of trauma-informed care that we were doing had a lot of steps that would help an agency have a safer workspace.

It also included thinking about how agencies are decorated, how color and quotes and different things can happen. I started this process a while back as I was working with agencies in the transformation from being a trauma-informed and gender-responsive organization, helping them to take pictures of their environment and their space, and as they change, to take “after” pictures so we can see the transformation. It became such a visual thing for me, so that with the help of some guidance around these topics, agencies were starting to transform to just be brighter places for people to come for care—safer waiting rooms, safer intake rooms. And it became just kind of the core of what I was very passionate about. And that’s why I developed that spin off training that I call creating trauma-informed and gender-responsive spaces.

**MS. FLANAGAN-FOLCARELLI:** I know that in your planning of the Consortium entryway and space, that you also took into consideration some of those pieces here. Can you say a little bit more about that?

MS. ANDERSON: Yes. I guess one of the first things Roger taught me way back when, when he came to see me in Torrington and I had this little tiny waiting room, was that I had this couch. And he didn't think people would be comfortable sitting on couches, because if you're a trauma survivor, you don't necessarily want to sit down on a couch and have somebody sit side by side where their body would touch you. I had never thought about that.

So I purchased a second couch where there was some dividers, but yet it was screwed together, and when he saw that he said, "That's like train style seating, and you still can't move your chair where you want to go."

When I got to the Consortium, there wasn't really a waiting area for people. And as I designed the waiting area, I was working with a group, and they kept showing me plans of what they could put in the lobby. I kept saying, "But I don't want a couch," and they kept putting a couch. So what we did is we designed a couch that had separation, so there were three seats, and it could be pushed together as a couch, but could also be separated. And I started to show that to other people and talk about the fact that we need to have spacing between where people sit and different options.

The other piece that we sometimes weren't thinking about in terms of options is the body sizes of different people. Sometimes people come in for care and need a bigger seat. So we started to think about seats that were wider, more comfortable, and a variety of seating types. That's how the lobby came to be, where it had some high seats, low seats, wide seats, and a couch that separated out. And those pictures were added to the training that I do. I actually have a PowerPoint of all the before and after pictures, and I show folks how you can transform your lobby to have a more trauma-informed space.

**MS. FLANAGAN-FOLCARELLI: I do think that trauma-informed design is so fascinating—just the example of the couch really illustrates all the different places where this work is important and useful to consider.**

MS. ANDERSON: And just letting people think about their own space. When I do the spaces training, you could talk about a place in your home, you could talk about a place in your office. And some people don't have offices; they have cubicles, and

what makes a cubicle feel safer to you? When we just redesigned the back area here in the cubicles, with COVID we added that glass at the top, so that if someone stands, they can see over their cubicle and around without necessarily being right on top of somebody. I'm always thinking about what's the next thing to do to ensure good space for people.

**MS. FLANAGAN-FOLCARELLI: So aside from trauma-informed design and thinking about spaces, are there any new developments in trauma-informed care that you are particularly excited about right now?**

MS. ANDERSON: I think when we first began some of the work, there was not as much going on around resiliency. Tying into the work that's happening now nationwide regarding resiliency is a more hopeful way for people to understand that if we can develop some of these practices, that will help with people getting better and be more successful in their recovery. So making the link between the ACES, the trauma and gender work, and now bringing in the resilience piece, I think is just moving it to the next level.

**MS. FLANAGAN-FOLCARELLI: So do you see this resilience piece as kind of the next frontier of this work? Or would you say that there's a different next frontier?**

MS. ANDERSON: Well, for me, I think that piece is really important for when I think about what's going on in Connecticut—a couple of the pieces that we're working on that are under development right now. We worked a lot on our Fidelity scale that we developed. It started as a self-assessment years ago with the work I did with Roger, and then with Roger and Stephanie Covington, we moved to have it be more gender-inclusive, and now we have developed it into a digital tool so that people will be able to walk through their agencies and see how they score on the fidelity scale. And the goal is to help agencies go from being trauma-informed to really being trauma-responsive and to moving up on the scale that we've developed. So I think that's really important. And I give both of them a lot of credit, as well as Eileen Russo, for the work on that fidelity scale. And then when we brought in the additional gender pieces to that tool, we worked with True Colors, and we made sure we added a lot of elements that broadened

our thinking about gender. When we first started talking about gender 20 years ago, we were thinking male/female, and we think about gender very differently now. And so there's a lot more work in the area of gender that's been happening as well.

**MS. FLANAGAN-FOLCARELLI: Could you say a little bit more about the difference between trauma-informed and trauma responsive?**

MS. ANDERSON: Well, trauma-informed is where people understand the concept and they know that it's going to be beneficial, but they haven't really taken the next step to what they have to actually *do* and implement. And they're responsive when the tools and the pieces are all in place and these things are happening. So you get a different score if you're trauma-informed as opposed to trauma-responsive.

**MS. FLANAGAN-FOLCARELLI: What is one thing that you think everyone should know about trauma?**

MS. ANDERSON: Well, the one thing I would say is most people in our society have been affected by trauma. When you take the ACES survey, you do that with staff or you do that with agencies, you do that with family members, you realize that the majority of people that we come in contact with every day have some ACES or trauma that they've experienced in their lives, and based on how many traumas they've had, what their life cycle might be like.

Years ago, we used to think that the folks with severe mental illness were ill because they had a mental illness. They took these medications, these very strong medications, for many years. They were high smokers, they smoked a lot, and their physical health was bad. And we kind of associated the physical health piece to the medications and the smoking and the poor diets.

And as I learned more about trauma, I started to realize that was not necessarily the case, that if you have had these traumas in your life, there's more likelihood that you're going to develop medical complications as well and that there's such a body link to the work that we're doing. When we think about trauma, I try to think about the fact that anybody I come in contact with could be a person who has had trauma, and it has caused me to pause more and to be more respectful of everybody else's life journey.

**MS. FLANAGAN-FOLCARELLI:** I think that's a really important consideration, because I know in my experience prior to joining the Consortium and working here, the idea of trauma felt like a very removed thing. . . this idea that actually so many of us, and perhaps *all* of us in some way, are affected by trauma is, I think, a shift in mentality.

**MS. ANDERSON:** Yeah, I think we all would say things that happened as we were growing up, and our families and our family dynamics and that sort of stuff, and a lot of times you hear people blaming their development—"If this hadn't happened when I was growing up. . ."—but then you actually do the ACE survey and you realize that some of these significant things that happen in people's lives affect them for their entire lives, and unless they work on those things and try to heal from them, they are going to have medical complications and mental illness and substance use problems.

I guess the other thing is a lot of times when we were first starting this, people kept saying, "Is this the flavor of the day? Is it going to go away? Is DMHAS paying attention to this now, but in a few years they'll forget about it?" Well, they haven't, it's been over 20 years. There's still the Trauma and Gender (TAG) Learning Collaborative that we host with DMHAS every other month, and we bring in speakers and presenters. There is the trauma toolkit that we designed here at the Consortium based on the work that we did for systems change. That toolkit has had several evolutions. The initial one was primarily for behavioral health. The second toolkit was designed with criminal justice individuals in mind. The third kit was developed with women and children in mind, and we're still seeking funding to be able to offer the systems change piece to the community providers. We recently put in a grant to again try to get funding to roll out another initiative for a group of agencies. So we're always hopeful that that work is going to continue, and we continue to evolve our tools.

**This interview has been abridged for length and clarity.**

**To listen to the full version, visit:**

[www.womensconsortium.org/podcasts](http://www.womensconsortium.org/podcasts)

## Who's Been Reading Trauma Matters? Commissioner Nancy Navarretta!

The Connecticut Women's Consortium wishes to congratulate *Trauma Matters* reader Commissioner Nancy Navarretta, who was unanimously confirmed by the Connecticut General Assembly during the 2022 legislative session. Commissioner Navarretta joined the Department of Mental Health and Addiction Services in 2013, first serving as director of behavioral health services and then becoming Deputy Commissioner two years later. As Deputy Commissioner, she was responsible for helping develop the Department's strategic planning and continuous improvement of its public-private partnerships, which provide one of the nation's most comprehensive continua of mental health and addiction services, supports, and lifespan prevention networks. Upon her appointment, Governor Lamont commented "Nancy has dedicated her career to behavioral healthcare service delivery and improvement and is highly regarded among her peers throughout the region, including the many private providers the state partners with for these services. We need strong leadership on these issues at this time, particularly when it comes to the impact that the opioid epidemic is having on our country and the growing mental health needs resulting from the impact of the COVID-19 pandemic. This is an important responsibility, and I appreciate Nancy for agreeing to help lead Connecticut's efforts on this front."

The Department provides adult behavioral healthcare to approximately 100,000 individuals annually. In addition to operating two state hospitals, it partners with

local mental health authorities and more than 150 contractors in the private sector. Commissioner Navarretta came to the Department with many years of experience as a direct service mental health and addictions provider and behavioral healthcare administrator. She maintains memberships with American College of Healthcare Executives (ACHE) and the American Counseling Association (ACA). She received her BA in Psychology from Boston College and completed her graduate studies at Fordham University with a MA in Clinical Psychology. Commissioner Navarretta is Nationally Certified and a Licensed Counselor in Connecticut and Massachusetts, and she has also maintained a general outpatient private practice since 1996.



**Commissioner Nancy Navarretta, pictured above with a copy of *Trauma Matters*.**



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[www.womensconsortium.org](http://www.womensconsortium.org)

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### Featured Resource: The Center for Endometriosis Care

The Center for Endometriosis Care, a medical practice in Atlanta, Georgia that specializing in treating endometriosis. Includes extensive resources: <https://centerforendo.com/>

### Comparative Suffering and Self-Compassion

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### Ask the Experts: An Interview with Colette Anderson, LCSW

Connecticut Women's Consortium [Trauma Services Directory](#)

Connecticut Women's Consortium [Trauma Matters Archives](#)