The Connecticut Women's Consortium

Trauma Matters

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

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www.womensconsortium.org

Rehabilitation

by Hope Payson, LCSW, LADC

Thirty-four years ago, while detoxing in a 28-day drug and alcohol rehabilitation program, I decided to pursue a graduate degree in Social Work. My Counselor told me this was a distraction from my recovery, but I knew the structure and focus would be lifesaving. Three years later, I got my first job in the field. My meager salary doubled and while it remained meager, I called a real estate agent to find out if I could buy a house. There were two options—a cabin in the woods that was essentially being held up by a tree and a condemnable house in a small town in Northwestern CT. Many suggested this was a bad idea, but I stubbornly bought the house anyway.

The former owners had left behind their belongings, bedroom walls covered in graffiti and punctuated with gaping holes, an infestation of bugs, and a host of problems I had no money to fix. The night of the closing, I sat on the floor of the living room, scratched the bites on my arms and legs, and cried. I was a shaky three years sober, struggling with PTSD symptoms that threatened my recovery daily and I'd bought a house as broken as I felt at that time.

But this house and I healed together. First off, I hired someone to usher out my unwanted little roommates and the constant itching stopped. I carefully repaired the holes and painted the walls in colors I loved. On the nights I could not sleep, I would watch the headlights from the road play across them and felt a sense of satisfaction and peace. Digging beneath the old carpet to find maple flooring, I discovered that there can be beauty hidden beneath an unattractive surface. Before my brother died of his own unaddressed trauma and addiction, we put new siding on the house together. Those weeks of working with him are some of the best memories I have of us.

I have a long history of running when things get tough, but my mortgage held me firmly in place. Over the years, when I impulsively tried to sell the house, no one even came to look at it. The house grounded me in place long enough to make good friends, attend therapy, stay still, face my pain, and reclaim and redefine my life.

In the past thirty-four years, I've used this house as collateral to buy a new home with a loving, long-term partner. I rented it to a woman who started her own healing journey there. Later, I converted it into a therapy office where 100s of people started their lives over. This house has served me, and so many others, well. When I closed my practice and there was no longer any need

for me to keep the house, I held on. Six months ago, I put it on the market, and it sold in ten days. I sat on that same living room floor and cried because it was time for me to move on.

It would be hard for me to recount everything I learned from this piece of real estate or thirty-four years of recovery. But this I do know—every human being wants to heal, and when given the right conditions they can. Inside us all, buried beneath our grimy layers of hurt, there is a part of us waiting to shine again. There is a part of us that knows just what we need. We simply need the time and space to distinguish the difference between the voice of our pain and the voice of our heart. Refinishing floors and painting walls will give you plenty of time.

In my life, I've made many good decisions that came from my heart. They did not always make sense to my brain at the time or the brains of others. But I'm okay with that. Buying that house was a pivotal life step and the significance of that choice was not entirely clear to me until I sold it. At first, I wasn't sure why I cried when I heard that someone had bought it, it simply did not make sense to my brain. But my grateful heart knew exactly why.

To learn more about Hope's work, visit her website, www.hopepayson.com.

Grief as Exile

By Michael Rowe, PhD

Exile is as old as civilization. Adults, children, political leaders, artists, and writers—famous and unknown—have fled or been forced to leave their countries by tyrannical regimes, floods and famine, and the slave trade. With exile comes grief over the loss of homeland and friends and threats to one's work, identity, and security.

Deep grief is a form of exile that doesn't require the grieving to leave their homes. They can simply stand at the window and watch friends and acquaintances walk past on their way to the corner store for a gallon of milk, oblivious to the fact that the world has changed utterly. They have moved on quickly after brief shock and sorrow over the other's loss. In fairness, though, there are few structures or rituals to help the non-grieving attend to another's grief in more than a passing way. And in the meantime, they face the daily task of keeping on to keep up.

The efforts of those who do extend their grief watch may come across awkwardly at times, as with passing along grief manuals that get it wrong from the start, focusing on the grieving one's recovery while appearing to accept the loved one's disappearance from the world as a given. This, in turn, cements the understanding of the grief-stricken that the world has forgotten their loved ones. It's as though they never existed.

More rarely still will the non-grieving convey to the grieving an awareness that the latter have gained knowledge and wisdom through their suffering, and can offer this to others. Failing this, the intensity of their grief further persuades the grieving that the world doesn't want what they have. And this accentuates their experience of the sacredness of their grief compared to the hollowness of a world that pushes them away. The grieving will not give up this sacredness simply to be allowed back in.[1]

There's an idea I've come across—I don't recall where—about grief being its own country and offering its own citizenship. I'm not sure about this. I've studied and written about citizenship, especially the social and collective aspects of it, for a long time. Griefworld is so isolated, and isolating. And Griefworld, for all of its unique sights, smells, and sounds, is a shadow world. Sacredness acknowledged, just about everything that happens in that world happens in part in relation to Lifeworld, even if Lifeworld pretends not to notice.

Return from exile comes in part with time, with the basic human urge to live and not die, with reminders of one's longtime dreams and hopes, and from the sheer force of everyday life. With this return comes reconnection with friends and acquaintances (though not, perhaps, to some who failed them most miserably). One day the grieving person walks down the street, too, to buy a gallon of milk at the corner store. A shudder of guilt passes though. This person has just graduated to the early adolescence of deep grief. Soon he, she, or they will step off the boat, a traveler home from exile. And it will hurt.

What to do about all this? That might be a question for another *Trauma Matters* article. But the question partly gets it wrong. 'What to do' includes recognizing and accepting others' grief and then trying to help, recognizing that you can't fix their grief but you can offer your caring and support. These are personal matters, but they're social matters, too. We need the grieving, whom just about all of us will be ourselves, as we need to maintain the dead in memory. They contributed while they were here, and continue to contribute through those who know them best.

1. See also Jonathan Lear on this, in Imagining the end: Mourning and the Ethical Life.

This article was adapted from Michael's blog, American Grief, www.rowewriting.com.

Beyond Bars: The Mental Health Challenges of Reentry

By Eva Michelle Bryant, LMSW

Last week, I had a conversation with someone I hadn't seen in a while, and they shared with me their recent experience of spending a few weeks in jail. They described the traumatizing environment of jails and the mental struggles faced by inmates due to the dehumanizing conditions.

It's important to recognize the challenges that individuals face upon release from prisons and jails, especially those dealing with mental illnesses. In the United States, over 7 million people are released from jail and more than 600,000 from prison each year, with many experiencing recidivism within three years. This population is highly vulnerable and requires ongoing advocacy.

Incarceration can lead to various stressors, including family disconnection, exposure to violence, overcrowding, and loss of purpose. Reintegrating into society post-release presents further challenges, such as securing employment, licenses, housing, and education.

Many individuals released from incarceration may exhibit symptoms of bipolar disorder, major depressive disorder, or post-traumatic stress disorder. Despite progress, mental health still carries a stigma, highlighting the need for continued advocacy for vulnerable populations, including those who have been incarcerated.

Access to mental health care in carceral settings is often minimal. Many individuals would benefit greatly from treatment

programs, therapies, and community support systems to help them successfully reintegrate into society.

To learn more about the State of Connecticut's transitional services for recovery and reintegration, visit www.portal.ct.gov/DMHAS/divisions/forensic-services/transitional-services.

Ask the Experts: An Interview with Dr. Tracey Meyers, PsyD

By Alana Valdez, Project Coordinator, and Marisa Pedron, Administrative Training Coordinator

Tracey Meyers is a licensed clinical psychologist specializing in neuropsychological assessment, trauma-informed therapies, and positive behavioral planning. With extensive training in integrative medicine, Tracey is also an advanced yoga instructor and therapist certified in MBSR, iRest, and Breath-Body-Mind. She lectures nationally and internationally on integrative medicine topics and has authored publications and book chapters on holistic behavioral treatments for mental health. In 2022, she published "Yin Yoga Therapy and Mental Health," exploring yoga's role in mental health and traumatic brain injury recovery. Tracey is on staff at Lawyers Concerned for Lawyers, providing mental health support, and works as a neuropsychologist for Synapticure, offering care for ALS, Parkinson's, Huntington's Disease, and Dementia. She is a faculty member at Maryland University of Integrative Health and the Center for Integrative Yoga Studies.

MARISA PEDRON: Your background spans clinical psychology, integrative medicine, and yoga therapy. How do these disciplines intersect in your approach to mental health treatment and support?

DR. MEYERS: That's a great question. And you know, as I was thinking back about my career—I was trained in the 1990s and it was a very traditional time—most of the psychology training was really from the neck up, right? It was all cognitive-behavioral, so the idea of looking at the body or working with the body was something that psychologists didn't typically do. My traditional training was in neuropsychology, so I did assessment and cognitive behavioral therapy.

In my own personal life, I became interested in yoga and mindfulness meditation and started sort of what I call having two lives. I would do psychotherapy during the day and then at night I started teaching yoga and I ran some mindfulness courses, so I had these two different worlds. But, little by little, they started to creep in, and at my day job—I was working at Connecticut Valley Hospital—people would start to say, 'Hey, do you want to do a yoga class?' So, I started doing some community yoga classes and then people were interested in learning mindfulness for the staff, so I started teaching mindfulness to the staff.

Then little by little, it started to impact my psychotherapy work too, working with clients, and I got more and more comfortable actually bringing those threads together. Now I can't imagine doing it differently because it's such a big part of the work I do with individuals and groups, which is really integrating the mind and the body. Now we know as psychologists and looking at the research, that it's not just working with the head, but it's also working with what's happening in the body. So those two separate lives have really melded into one, and it really helps the work I'm doing and it's much more rewarding for me as a clinician and as a practitioner.

ALANA VALDEZ: As we move forward as a society and think about behavioral health and how things have changed, holistic medicine and integrative medicine are becoming a lot more widely accepted. Seemingly, there are still some misconceptions and misunderstandings that people have; I think people can be resistant to that combination. What are some of those misconceptions or misunderstandings that people might have about the integration of holistic and traditional medicine?

DR. MEYERS: It's such a good question. For a lot of us, we have that misconception—I had it too—we just didn't have the understanding of how important the body was. Misconceptions about mindfulness and yoga, well, people will sometimes feel like it's religious, like there's a spiritual bend to it. And the traditions of mindfulness do come from Eastern contemplative traditions that are 2,500 years or more old. So, the roots are there, but it's really been utilized in secular settings, medical settings, and now in psychological therapy. So, moving from that idea that this is something you had to go to India to do, or somewhere in the Far East, and now we know this can be part of a regular [treatment] program.

In 1979, Jon Kabat-Zinn, who's sort of the founder of Western mindfulness, created the Mindfulness-Based Stress Reduction program, and it was really revolutionary because it was the first time that modern medicine started to embrace mindfulness as a practice to help with chronic pain and to help with all sorts of other ailments that we face in terms of stress.

I think since then, there's become this increasing focus on how it can really help with different physical and emotional challenges. Other misconceptions, you know, "I can't do it," that's the number one thing I hear from clients if I ask them, "Have you ever meditated?" They'll say, "I can't, my mind wanders too much, it's too hard for me," which is very understandable. The good news is that we all can do it because we all can breathe. [It's important to help] people realize you don't have to be able to in the beginning, especially sit and try to meditate for hours at a time—that's impossible.

But can you begin to integrate mindfulness while you're walking your dog in the morning or while you're taking a shower to feel the water on your body? We can use senses, we can use breath, we can use sounds: there are so many different ways to help us become more present, and that alone can start to help us feel better. That's one of the myths I really work hard on trying to dispel is that you don't have to be a meditator and you don't have to be good at it. And you can have very, very anxious, active thoughts going on and still get a lot of benefit.

For many of us, too, it isn't always a sitting practice. Maybe it's going to be mindful moving. Maybe it'll be yoga or Qi Gong or some kind of walking program, but we can integrate that into a daily lifestyle that can make a difference not only physically, but emotionally.

The last piece I want to say is the accessibility.

For some people, it can feel like, "I wouldn't know where to begin or I don't have anything in my local area," and now thankfully, really post-pandemic, [we have] the ability to hop on a yoga class online or have an app like the Calm app or Headspace. There are just so many accessible programs and with a little bit of guidance, you can really find your own practices without having to spend a lot of money or even leave your house. I think that accessibility piece has really opened the door for many people as well.

ALANA: I love what you said about it being a practice and a thing that people aren't inherently good at in the beginning. I think it's something where people just assume they can either do it or they can't, and there's no building up to it.

DR. MEYERS: The truth is our minds are designed to worry, plan ahead and not be present. It's like protection. So instead of saying, "Well, that's something wrong with me," [know] it's how we're designed. We have what we call a negativity bias, where our brains are wired to look for what could go wrong; to plan, worry, and anticipate. So that seems like, "Well then, how am I ever going to meditate?"

[We must] recognize we're all wired this way; in fact, the way to work with that is to help gently and slowly introduce this present-moment awareness, which a lot of us don't intuitively have because our brains are wired from an evolutionary standpoint to be looking ahead toward what could go wrong. I like to really normalize that all of us have that tendency to mind wander, to worry, to have difficulty focusing. It does take time: it just takes a little bit of training and some guidance to be able to use more present-moment awareness.

MARISA: Do you see a moment in your sessions when people who are hesitant or resistant decide to accept the process? How does that transition to openness affect them?

DR. MEYERS: I'm more—I guess—blatant about it. I will have people even rate their stress level before we do a brief practice just so they can really see for themselves, on a scale of one to ten, how stressed they are. A person may say, "I'm a seven or eight," and I might have them ask where they notice that in their body. Maybe they say, "I feel like a little bit of tightness in my chest or my belly," and then we'll do a very short practice, two or three minutes of breath awareness or a gentle body scan. Then at the end, I'll ask them again to rate their stress level on a scale of one to 10, and often—not always, but often—the number goes down. Sometimes a couple of notches, sometimes way down, and then I'll have them notice where they feel that in their body or what might have shifted so they're noticing it themselves.

Even if I notice—which is great when I do—it's important for them to have that direct felt experience and to be able to not only feel it, but then really verbalize it and feel it in their body. That can make a big difference in terms of wanting to do it more and feeling the effects.

MARISA: So much—not only therapy but also mindfulness—is a lot about accepting the moment you're currently in. As you said, it's challenging because that's not a survival tactic for us. If you're not thinking ahead, how are you surviving? I think that having to accept [being] present in both your body and mind is probably a very freeing experience for someone who is resistant to accept [that].

DR. MEYERS: I love what you're saying because that's one of the instructions sometimes I'll give people, even just accepting for now. If we have a feeling of distress, physically or emotionally, the idea of accepting it from now on feels really overwhelming. But if I can accept just for this breath or this moment [things are] like this. To even bring compassion in, like, if it's a difficult feeling, not only accepting it but saying, "Oh yeah, this is hard, I'm struggling." [It's] this idea of naming it. There's this expression in psychology: name it to tame it. It's this little funny adage, but it's the idea that when we're actually able to notice and accept for a moment what's happening, our level of distress goes down.

There's research documenting that the part of the brain, the amygdala, that fires when we're distressed—our fight, flight, freeze threat detector—calms down when we name our experience, just the act of naming it. When we notice something uncomfortable, we don't push it away, we don't pretend it doesn't exist, but can we bring it to awareness with compassion and just name it? So that's sometimes the beginning of a mindful practice: it's just what's happening now; what is it like? Bringing compassion, and that alone, can take [away] some of the distress.

MARISA: It kind of lets you give yourself some grace, like you're allowed to feel what you're feeling and that's okay.

DR. MEYERS: I love that "grace" term; if we can let ourselves just actually feel what's here to be felt. I have another little pithy saying—none of these are mine—but what we resist, persists. That's the same idea that if we push it away, it comes back, and sometimes even more intensely, or we turn on ourselves and feel bad about ourselves for feeling that. So, if we can just have the direct experience of the feeling without pushing it away or judging ourselves, or criticizing ourselves or blaming ourselves, then often the feeling can soften just by doing that. In the paradox of letting ourselves feel, feeling it helps it to dissipate.

MARISA: Can you tell us a bit about your work with Mindful Self-Compassion?

DR. MEYERS: [It's an 8 week] program based on the work of two psychologists, Kristin Neff and Christopher Germer. They're researchers who [look] at the power of self-compassion. I think about self-compassion as sort of the "Mindfulness 102" because it has the underpinning of mindfulness. There are three components to self-compassion. The first is mindfulness. Being aware of what's happening, this idea of being present with what's happening. If we're not present, we can't even bring compassion in because we're not aware of what's happening.

The second is kindness; it's meeting ourselves with kindness rather than blame, so if we are struggling with something instead of saying, "God, Tracey, I can't believe you're doing this again. What's wrong with you?" instead [I could] say, "You're having a hard day, Tracey. This is hard. This is a moment of suffering." [It's about] turning toward myself versus turning away.

The third part of self-compassion is recognizing I'm not alone, that [others] struggle just like me, that having anxious or worried thoughts or struggling with depression: other people feel this, just like me.

[Building the skill of self-compassion is] a muscle, just like mindfulness, just like physical exercise, because most of us tend to be a lot more compassionate toward other people. Research says about 80% of us tend to be much more compassionate to other people. When [we] look at ourselves, we tend to not be very compassionate, we tend to be hard, we blame ourselves. We would never talk to our friends and family the way we talk to ourselves.

[Mindful Self-Compassion] really helps us to turn toward ourselves with that same generosity and practice over and over again. How do we meet ourselves with more kindness? Why is that important at the end of the day? The self-compassion research shows

that we actually are more resilient, we are more motivated, less depressed, and kinder to other people when we're kinder to ourselves.

Earlier we talked about the myths for mindfulness. [There are] a lot of myths for self-compassion too: "If I'm kind to myself, I'm going to let myself off the hook. I'll be lazy. I don't deserve it." The research says we do better when we give ourselves grace, because that gives us the capacity to move forward in adverse situations.

ALANA: "Compassion", alone, is such a good word because kindness [is often associated] with empty nicety, but kindness [is really like compassion in that it's] about honesty and accountability.

DR. MEYERS: In fact, sometimes compassion is setting fierce boundaries. Sometimes compassion is saying no. So, it's not just all soft; another myth [is that it's all about being soft]. But it also can be, "I'm going to take care of myself, and this is what I need to do to do that." There is both a tender and fierce part of self-compassion. For women especially, we tend to move toward the softer side of compassion, but for many of us, myself included, working on those boundaries and helping myself to be able to set a limit is as important as being kind to myself as well.

ALANA: You also do work with Breath-Body-Mind. Can you explain what that is and how it relates to your other work?

DR. MEYERS: There's a couple of key things [that really draw me to these programs]. First, there's research to back them. I'm a psychologist at heart; I tend to want to look at the research and make sure what I'm doing isn't too out there; that it actually is grounded in science. I'm always drawn toward programs that have a strong scientific background and that also help with clinical issues. Both for my professional and personal development, [I want to know] does this [program] have a background in science? And does it help people alleviate suffering in some way; does it help with depression or anxiety or trauma? If it meets those two categories, then I'm really intrigued.

Breath-Body-Mind is [a program] developed by Dr. Patricia Gerbarg and Dr. Richard Brown. They created this mind-body program using breath and some gentle movement including Qi Gong to [address] things like depression, anxiety and trauma.
[Breath-Body-Mind] is very experiential. We really are working with the body over and over again, using different practices. Some of [the practices] help calm the nervous system, some of them help energize and get energy out and some like, coherent breathing, help us feel balanced. These practices are simple. I'm also drawn to our practices that are accessible.

I think when we make something difficult, we're not going to do it. But if something is as simple as learning how to count when we breathe, so coherent breathing, for example, we're breathing in and out to a count of four: that's all it is. We're slowing our breath down to about 5 breaths a minute, breathing in to a count of four and breathing out. And something that simple can have a huge shift in our nervous system regulation.

ALANA: I notice both programs focus on taking care of yourself, not only for your own benefit, but so that you can continue offering good work and good support to your clients. People in helping professions are often kind of martyring themselves and don't always think about the fact that you need to take care of yourself so that you can continue to offer a high-quality standard of care.

DR. MEYERS: If I can get clinicians and mental health workers and teachers into the door by saying, "You can use this with your population," then we can really work on some of the self-care, because it is both. There was a study that happened about 10 years ago where they looked at mental health clinicians that did a little brief mindfulness practice before they saw clients, and they compared it to a group of clinicians that didn't do that centering practice before, just like, a 5 minute breathing practice.

Then they surveyed the patients after the therapy session—and the clients didn't know whether they were working with the therapist that did the practice or not—and the ones that had gone to a therapist that did the centering practice before rated the session as more helpful than the ones that didn't. So, by doing our own practice, we're more available to the people we're serving and able to be more calm, more balanced, and more present moment focused.

Of course, [clients] can tell when someone's present and connected and calm versus distracted or worried themselves, it's like an energetic feeling. That other piece of it really helps our own clinical work when we have the tools ourselves and we're using them.

ALANA: I imagine it's also helpful thinking about vicarious trauma, too. [When I was a teacher], I would receive information I didn't necessarily want to receive and even if I knew that it was part of the job, it still was a kind of a burden for me to carry and to process. I'm sure that practices like these really help you develop some resilience as a clinician.

DR. MEYERS: They do. The ability to hold space for somebody, to be grounded in your own body, to be able to self-regulate takes having a practice. People go into the helping professions, whether it's teaching or mental health, to help people and often have a huge heart and are compassionate. [But] that can be very painful. I find particularly the body-based practices—being able to breathe and regulate your breathing, being able to have compassion for yourself when you are activated—really make a difference in terms of being able to hold a lot. These practices are sort of the antidote to compassion fatigue and vicarious trauma, because it is a lot of self-care and emotional regulation, every time we sit and we bring compassion into our bodies and our breath.

Each person we come in contact to after we've done a meditation practice is affected: our clients, our kids, our partners, our dogs. When we're even slightly more capacitated and slightly more present-minded, it makes a huge difference. I was thinking about this the other day with my teenager, she was telling me a very long story about school drama and I have so many things to do, so there's this part of my brain that's like, "I have to go do stuff," and then I say, "No, no, no. What is it like to hold space and really listen to your beautiful 15-year-old daughter?" So, you know, I brought compassion for myself, the distracted part of myself, and then [thought], "What a beautiful thing to be able to be here." Then I could feel the softening, and then I didn't care what I had to do.

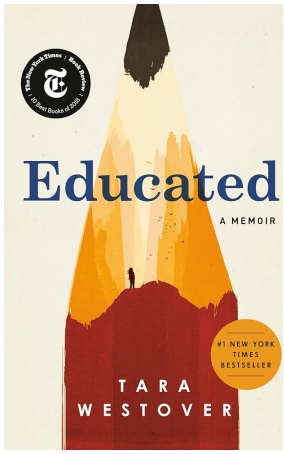
If I didn't have that awareness of both the impatient part of me and this deep desire to listen and be present for my daughter, it would have been easy to [not be fully present]. I was able to bring [truth to both experiences] and that was a direct result of my own practice.

This interview was adapted from the episode "Exploring Integrative Wellness with Dr. Tracey Meyers" from our podcast, Realizing Resilience. *Listen to more episodes on Spotify or our website, womensconsortium.org.*

Featured Resource: Educated by Tara Westover, MPhil, PhD

Review by Laura Williamson, MARc

My experience of reading *Educated: A Memoir* was punctuated by the universal relatability of being an outsider, an experience exemplified by Tara Westover's challenges as a young adult entering the world after being raised in a lifestyle shunned by "mainstream society." Throughout her memoir, Westover tells the story of her upbringing in a family gripped by paranoia and religious fundamentalism to weave a cautious message of hope in the face of harsh and complex social realities. As the title implies, Westover emphasizes the transformative role of education in bringing about her own mental and physical liberation.



Westover's prose is descriptive and poetic in places but is not unnecessarily complicated. Throughout the book, Westover approaches her parents' religious dogmatism—including a distrust of medicine, government services, and rejection of education—with a sensitive but unflinching truthfulness. Though she refuses to villainize her family's motives, she presents the consequences of their actions without varnish. While the book necessarily covers family and religious trauma, its major themes about confronting ignorance, isolation, fear, and "other"-ness are impactful for people from any background.

Ultimately, *Educated* is a story about the power of knowledge, finding one's own personhood, and confronting well-meaning but no less damning failures on the part of one's family, community, and society. Westover uses specific examples from her upbringing and subsequent experiences in higher education–including an eventual Ph.D. at the University of Cambridge–to expound upon the preciousness of education and its ability to elevate both the mind and soul. This book will break your heart and build it up again. I highly recommend *Educated* to anyone who longs to find proof that one can have hope in the midst of hell, inspiration in isolation, and peace in the midst of pain.

Who's Been Reading *Trauma Matters*?

Dr. Chyrell Bellamy!

Chyrell D. Bellamy, PhD, MSW, is a professor at Yale University's Department of Psychiatry, where she directs the Yale Program for Recovery and Community Health (PRCH). She also serves as the Director of Peer Support Services & Research and heads the Yale Lived Experience Transformational Leadership Academy (LET(s)Lead). Additionally, she works as a Senior Policy Adviser for the Office of the Commissioner for the State of Connecticut Department of Mental Health and Addiction Services (DMHAS).

Dr. Bellamy specializes in community-based participatory research and co-design with communities of color and those living with psychiatric illness, substance use disorders, HIV, homelessness, and incarceration histories. Her research focuses on healthcare disparities, sociocultural pathways of recovery, culturally responsive interventions, and qualitative research methods. She is also involved in developing and training on psychosocial and wellness interventions.

As Director of Peer Services and Research, Dr. Bellamy provides instruction on peer curricula development and training, drawing from her extensive experience with peer employees since 1993. She conducts research and evaluation on the effectiveness of peer support and provides leadership training for individuals with lived experiences through the LET(s)LEAD Academy.

Dr. Bellamy's work is deeply personal and professional, informed by her frontline service provision, clinical practice, social work, community education and organizing, training, program evaluation, and research in health and behavioral health. She openly identifies as a person with lived experience of multiple marginalized identities, including mental illness, trauma, and addiction, which informs her research and community practice.

A Note from the Editor

Dear *Trauma Matters* Readers, your voice matters! Help shape the future of our publication by filling out our survey. Your insights are invaluable in ensuring that *Trauma Matters* continues to provide the most relevant and impactful information on trauma.

Scan the QR Code or click here to complete our survey.

Are you an expert on trauma, represent an organization providing trauma-informed care, or have lived experience with addiction or trauma? Share your knowledge and insights with our community by submitting articles to *Trauma Matters*. Whether you have a narrative, research findings, case studies, or best practices to share, your contribution will help us to educate and empower others in the field. Be a part of the conversation that shapes the future of trauma care!

Scan the QR Code or click here to propose an article.

The Connecticut Women's Consortium

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References and Resources

Resources

Tracey Meyers, PsyD: https://www.traceymeyerspsyd.com

References

Quandt, K., Jones, A (2012). Research Roundup: Incarceration can cause lasting damage to mental health. Retrieved from https://www.prisonpolicy.org/blog/2021/05/13/mentalhealthimpacts/

U.S. Department of Health and Human Services (n.d.). Incarceration. Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/incarceration

Westover, T. (2022). Educated: A Memoir. Harper Perennial.