

# TRAUMA MATTERS

Fall 2014

A publication produced by the CT Women's Consortium and the CT Department of Mental Health and Addiction Services in support of the CT Trauma Initiative

## INSIDE THIS ISSUE:

The Importance of Cultural Competence in Trauma Recovery 1, 2

Trauma-Informed Correctional Care (TICC) 2, 3

Ask the Experts: A Conversation with Dr. Vincent J. Felitti, MD 4

Recovery Network of Program's Journey 4, 5

OF NOTE: Dr. Jackson Katz, PhD to Speak on Gender Violence 6

## The Importance of Cultural Competence in Trauma Recovery

Let us first distinguish between culture, race, and ethnicity. Culture is the traditions, values, and customs shared by a group of people. Culture provides a conscious structure for social relationships that helps make meaning of the physical world or environment in which one lives. This meaning transcends generations through language and everyday interactions, including learned behaviors that encompass values, beliefs, attitudes, cognitive styles, and knowledge (Marsella, 1988). From the teachings of Carl Jung, we might even go so far as calling it the "collective unconscious."

Ethnicity is a more subjective concept: individuals or groups often share a common culture, or parts of that culture, yet identify with different ethnic groups. Race was a term initially used in the scientific classification of the human species to indicate genetic phenotypes. However, many scientists believe that this is an outdated hypothesis, and theorize that humans belong to the same genus and species of *Homo sapiens* and to the subgroup *Homo sapiens sapiens*. In modern ideology, race is based on phenotypic features, such as skin color, as well as an individuals' perceived identity (Lewis, 2000).

As we know, humans have the ability to experience and express basic emotions: anger, contempt, disgust, distress, fear, guilt, interest, joy, shame, and surprise (Izard, 1994). When individuals experience a traumatic event, or events, their capacities to cope with stress and connect with their communities are crucial. Culture and personal uniqueness are strong aspects that account for how an individual manages stress and exhibit symptoms of Post Traumatic Stress Disorder (PTSD). Research shows that symptoms such as intrusion and arousal appear to be universal, while symptoms of avoidance and numbness tend to be culturally based (Friedman & Marsella, 1996). Research also suggests that to fully understand the relationship between trauma and culture requires an understanding of the particular cultural system. What are the dimensions of the psychological trauma and cultural systems as they relate to the patterns of daily living? How does a particular culture create a mechanism to assist individuals who have suffered significant traumatic events? How do cultural rituals and religious practices influence an individual's resiliency to cope with psychological trauma? How do cultural values shape the meaning of a traumatic event? Understanding the intersection of trauma and culture and the unique lens it creates for an individual is invaluable in providing successful clinical supports and interventions.

As an example, Native Americans generally believe that in order to heal, the physical, spiritual, emotional, and mental spheres of the self must all be equally addressed. For Native Americans, living a balanced life inclusive of community is an essential part of living healthy. "The people are dependent on the family and the tribe and the family and tribe are dependent on the people. Living a healthy balanced life will ensure continuity in the revolving circle of American Indian life for our children and our children's children." (A. Morsette: [www.giftfromwithin.org](http://www.giftfromwithin.org)).

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Because of this cultural belief some individuals may benefit from receiving collaborative or parallel services from a caregiver in their community, in this instance, a tribal leader.

As with the Native American culture, Asian or Asian-American families have specific cultural beliefs that influence how they may understand and react to traumatic experiences. A cultural norm for this population is to turn to elders within their family for advice. Clinicians can provide support by first understanding that an Asian woman often considers the impact speaking about her trauma will have on her community and family before considering how disclosure will help her to gain services and relief. Morsette captures this best when he says, “an Asian American woman may perceive the abuse as representing a deviation from her family’s dreams for her success” (L. Batra, Ph.D.: [www.giftfromwithin.org](http://www.giftfromwithin.org)). Clinical interventions that premise she take care of her needs first may not be well received. Rather, validating her belief system and assisting her in identifying and relying on supports both inside and outside of her family could be very helpful in processing her trauma.

Universal cultural barriers to treatment may include language, financial resources, family expectations and standards of success and the presence of traditional gender-specific roles identity. Cultural norms are often significantly influential in an individual’s sexuality and expression. “A sexually abused Latina may view herself as “danada” or “damaged goods” because she no longer meets the cultural standard for a girl’s purity and chastity (called Marianismo) and her family may share this view (Fontes, 2005; Kenny & McEachern, 2000). Machismo, the man’s responsibility to provide for and protect his family, also affects the way a Latino family may deal with sexual abuse and traumas” ([www.NCTSN.org](http://www.NCTSN.org)). Additionally, cultural religious beliefs often play a significant role in how an individual interprets traumatic experiences. Concepts of blame, guilt, responsibility and suffering are often defined by cultural background. Latino and Hispanic cultures often turn toward spiritual beliefs and religion in times of stress making it advisable to incorporate spirituality and religion into the treatment process. This may include working with the client and caregivers through themes of guilt, punishment and self-sacrifice.

Culturally competent services are fundamentally grounded in understanding that all healing and recovery is person specific. Taking the time to learn about the person’s history and experience in consideration of their culturally influenced beliefs and values improves clinical treatment and builds capacity for effective trauma treatment and trauma-informed care.

*Submitted by Rosanne Arpaia, BS*

For a complete list of references for this article please visit: [www.womensconsortium.org/references\\_Trauma\\_Matters.cfm](http://www.womensconsortium.org/references_Trauma_Matters.cfm).

## Trauma-Informed Correctional Care (TICC)

***This article is a continuation of a series examining trauma and trauma-related experiences among incarcerated individuals, an often overlooked population when it comes to assessing and treating trauma either upon initial contact with the correctional system or upon release. The series focuses primarily on trauma in men within the prison system (nationwide men comprise 91.3% of incarcerated individuals) as well as the development of Trauma-Informed Correctional Care (TICC).***

The recently published Treatment Improvement Protocol 57, “Trauma-Informed Care in Behavioral Health Services” (SAMHSA, 2014), defines trauma-informed care as “a strengths-based delivery approach ‘that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment’ (Hopper, Bassuk, & Oliver, 2010, p. 82). It also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to re-traumatize individuals who already have histories of trauma, and it upholds the importance of consumer participation in the development, delivery, and evaluation of services (p. xix).”

Increasingly behavioral health providers recognize the role of trauma in the lives of their clients and are developing systems of care that can be characterized as “trauma-informed.” Attention is also turning to trauma-informed correctional care (TICC) given higher rates of trauma histories among correctional populations as well as increased potential for both new and re-traumatization within correctional facilities. (See *Trauma Matters*, Summer 2014). For example a recent federal inquiry as reported in The New York Times (August 4, 2014) described conditions in the Rikers Island (N.Y.C.) Correctional Complex as a “deep-seated culture of violence” against its youthful inmates (ages 16-18) and suggested that the identified problems “may exist in equal measure” in the island’s seven other jails for adult men and women. One may reasonably conclude that significant traumatization and re-traumatization occur within this environment. The report also noted that juvenile inmates with behavioral disorders appear to be the targets of some of the most extreme violence.

So to what extent can trauma-informed care principles be applied to a correctional setting given its very different

goals from a behavioral treatment setting? Miller & Navajits (2012) acknowledge that introducing TICC into prisons is challenging. "Prisons are designed to house perpetrators, not victims. Inmates arrive shackled and are crammed into overcrowded housing units; lights are on all night, loud speakers blare without warning and privacy is severely limited. Security staff is focused on maintaining order and must assume each inmate is potentially violent. The correctional environment is full of unavoidable triggers, such as pat downs and strip searches, frequent discipline from authority figures, and restricted movement. (Owens, Wells, Pollock, Muscat & Torres, 2008). This is likely to increase trauma-related behaviors and symptoms that can be difficult for prison staff to manage (Covington, 2008). Yet, if trauma-informed principles are introduced, all staff can play a major role in minimizing triggers, stabilizing offenders, reducing critical incidents, de-escalating situations, and avoiding restraint, seclusion or other measures that may repeat aspects of past abuse (Blanch, 2003; CMHS, 2005)." Furthermore, specific trauma treatment interventions may assist with the resolution of substance use issues, domestic violence and recidivism.

**There are many practices that promote TICC. Some of the primary practices include the following:**

- Ensure a correctional environment that is highly structured and safe with predictable and consistent limits, incentives and boundaries as well as swift and specific consequences so that inmates are treated fairly and equally.
- Provide education and training for correctional staff which includes information about trauma as well as ways to respond effectively to trauma symptoms.
- Screen new inmates for trauma histories.
- Use cognitive behavioral interventions to restructure criminal thinking and develop positive coping skills.
- Utilize trained staff to offer evidence-based specific treatment interventions for trauma.
- Address secondary traumatization among all corrections staff.

While there is continued growth in both theoretical and research-based literature about trauma and trauma-informed care among prison populations, disparities exist. In general it appears that while trauma issues among incarcerated women receive the bulk of attention, less attention has been focused on incarcerated men. Trauma-informed correctional care, while described well in principle and theory, appears to have been instituted minimally in men's correctional facilities and with relatively more frequency in women's and juvenile detention facilities. Literature searches reveal minimal information on correctional systems attempts to integrate TICC and/or discussions on the challenges, successes and barriers in making an institutional shift to TICC.

**The National Center for Trauma-Informed Care (NCTIC Marketing Brochure, SAMHSA, 2012) briefly describes several instances in which TICC changes were successfully enacted:**

- The North Carolina Department of Juvenile Justice has re-written job descriptions, eliminated the requirement for security-type uniforms, and provided "comfort bags" of sensory items to all youth.
- In Florida, one juvenile justice facility has repainted its cells to be welcoming rather than jail-like and, whenever possible, provides incarcerated youth their choice of rooms.
- The women's prison in Hawaii has also made changes to the physical environment as part of an overall effort to become trauma-informed. In addition language has been changed (e.g., "what happened to you?" not "what's wrong with you?"), both staff and inmates are educated about trauma and its impact, and universal trauma screening has been implemented.

**So where are we when it comes to more widely adopting TICC practices in correctional facilities, particularly those facilities which house male inmates? The answer to this question is actually a subset of questions remaining to be fully answered:**

- Will some of the principles of TICC be considered so incompatible with the objectives of incarceration (e.g., control) that change is not deemed realistic?
- Will decision makers discount the role of trauma and its life-changing consequences within incarcerated populations?
- Will the belief that primarily women are subject to trauma and its effects and that trauma does not play a significant role in men's lives continue the disparity?
- Will the belief that incarceration is punishment prevail over the concept of incarceration as rehabilitation?
- Will the perceived cost of transforming correctional facilities be perceived as too much of an expenditure to justify its implementation?
- Is there any evidence at this time that TICC could potentially reduce costs and recidivism in the long term (particularly for men)?

The answers to these questions remain for the most part unclear despite increasing efforts by some individuals and groups to understand and apply TICC to forensic and corrections settings. For now, growing awareness and ongoing discussion of TICC systems change can help support positive shifts toward improved incarceration outcomes.

*Submitted by Steve Bistran, MA*

For a complete list of references for this article please visit: [www.womensconsortium.org/references\\_Trauma\\_Matters.cfm](http://www.womensconsortium.org/references_Trauma_Matters.cfm).

## Ask the Experts: A Conversation with Dr. Vincent J. Felitti, MD

**A** renowned physician and researcher, Dr. Vincent J. Felitti is one of the world's foremost experts on childhood trauma. He is co-principal investigator of the internationally recognized Adverse Childhood Experiences (ACE) Study, a long-term, in-depth, analysis of over 17,000 adults. Defying conventional belief, this study famously revealed a powerful relationship between our emotional experiences as children and our physical and mental health as adults. Founder of the Department of Preventive Medicine for Kaiser Permanente, Felitti served as the chief of preventive medicine for over 25 years. Felitti's revolutionary health risk abatement programs incorporated weight loss, smoking cessation, stress management, and a wide range of cutting-edge efforts to reduce patient risk factors. Dr. Felitti also has served on advisory committees at the Institute of Medicine and the American Psychiatric Association".

Retrieved from: <http://www.apbspeakers.com/speaker/vincent-felitti>

### **Q: Why did you enter the trauma treatment field?**

**A:** By accident, because of the annoying behavior of patients in our obesity program who were fleeing their own success, dropping out, and quickly regaining all their weight. One particular patient in 1985 made us see that her obesity was protective against the chronic sexual threat she felt as the result of a long incest history with her grandfather. As a result of this, we quickly uncovered sexual abuse histories in other patients, then other forms of abuse, then growing up in massively dysfunctional households. This was so commonly acknowledged when meaningful patient histories were routinely obtained that the question soon arose as to whether these experiences were at all common in a general population, and if so, how did they play out over time. This was the purpose of the Adverse Childhood Experience Study and soon we realized we had entered very deep waters.

### **Q: Can you tell us what you consider to be the most helpful stabilization skill or tool one can teach to a trauma survivor?**

**A:** That what has happened to them is far more common than believed, and can be spoken about without destroying their acceptance by supportive human beings.

### **Q: What is one thing you believe all trauma-focused clinicians should know?**

**A:** That it is well within their ability to be meaningfully helpful to these patients, and that their claimed lack of time, training, insurance coverage, and patient acceptance are their own defenses against fulfilling their capacity to be meaningful in their chosen work.

## Recovery Network of Program's Journey

***Recovery Network of Programs, Inc. (RNP) is a private, non-profit behavioral health provider serving southwestern Connecticut. It provides both outpatient and residential services to individuals recovering from behavioral health and / or substance issues.***

*"A journey of a thousand miles begins with a single step."  
Lao-tzu*

**R**ecovery Network of Programs (RNP) journey in the provision of trauma-informed and gender-responsive care officially began with an award to participate in the Practice Improvement Collaborative with the Department of Mental Health and Addiction Services (DMHAS) and the Connecticut Women's Consortium (CWC) in August of 2011. RNP has reaped countless benefits as the result of its participation in this initiative. At the time of the award, RNP knew the following: (1) We were (and remain) deeply committed to improving and individualizing services for each person served (2) internal data indicated we were serving an extremely high percentage (82%) of individuals who had experienced some form of trauma, and (3) the Trauma and Gender (TAG) Initiative fit perfectly within RNP's philosophy of client care as well as its strategic plan.

In little over two years, RNP has achieved significant milestones in improving all aspects of clinical care, and it has taken extraordinary measures to improve the environmental and physical spaces where services are provided. Shortly after our award, RNP assembled its first TAG Steering Committee, a group of enthusiastic and committed employees and consumers who lead and guide the agency's work in this vital area. The following is a summary of our efforts to improve outcomes and services. These can be applied within any organization at any level of care.

**Understanding Trauma-Informed and Gender-Responsive Care - Expanding the Lens:** Among the first goals identified by RNP was the need to train and educate its staff on trauma-informed and gender-responsive care. This education was based on redefining trauma, with the presumption that every individual seeking treatment has likely been exposed to trauma, or experienced some form of it (which is the core concept of trauma-informed care). In addition, it was essential to educate all staff that men and women respond differently to trauma and, thus, recover differently. In the two years RNP has participated in the TAG Initiative, we have trained over two hundred staff members. Essential to our success is our commitment to train and supervise staff from all departments, including Human Resources, Finance, Operations, Security, Administration, Recovery Coaches, Peer Mentors and Medical, and Clinical Services. Throughout RNP, treatment and services are now organized to integrate an understanding of the impact and consequences of trauma in

all interactions among staff and with individuals served. We recognize that every one of us at RNP has a role in creating, sustaining and supporting an individual's recovery.

RNP has always placed great emphasis on employee health and well-being. The TAG Initiative has provided the opportunity to think outside the box and offer many professional self-care activities to staff that include the following: outdoor team building exercises, day trips, celebrations for staff achievements, auricular acupuncture, smoking cessation groups, and a commitment to the highest level of clinical supervision and support.

**Organizational Change:** RNP leadership and its Board of Directors have played a significant role in leading and sustaining change. Upon receipt of our TAG Practice Improvement Collaborative Award, John Hamilton, RNP's CEO, engaged leadership staff and the Board of Directors in all areas related to the Initiative. As a result, RNP's senior leadership team and Board of Directors are well-informed and support, as well as advocate, TAG services. During this time, RNP's Mission Statement was revised and updated to more accurately reflect the current work of the agency. In addition, RNP utilized this Initiative as an opportunity to strengthen an existing approach to client care that focuses on relationships and affirms organizational values that advance trauma core principles, such as safety, trustworthiness, choice, collaboration and empowerment. RNP's revised Principles to Client Care now highlight trauma-informed and gender-responsive care.

**Physical and Environmental Changes:** Some of the most unanticipated outcomes of RNP's participation in the TAG initiative include sweeping physical changes made to new and existing programs. In June of 2013, RNP opened the doors to the Tina Klem Serenity House. There are few words that accurately capture the beauty that exists within the four walls of this DMHAS-supported Recovery Home. The interior space was designed as a collaborative effort between the University of Bridgeport's School of Design and Carey Dougherty's "Her Haven," a non-profit company serving women by redesigning spaces for women to thrive, dream and prosper ([www.herhaven.org](http://www.herhaven.org)). Both groups took extraordinary measures to create unique, welcoming, safe places for women who are seeking a program in which to build a strong foundation for addiction recovery. Creating such a beautiful physical space raised the bar within the organization to improve the environment of each RNP program. This past June, RNP and Dougherty completed major renovations at Prospect House, an emergency shelter for individuals who are homeless. Under Dougherty's direction, staff and residents selected furnishings, welcoming and symbolic paint colors, new flooring, wall décor that include displays of employee photos (thereby reinforcing trust and transparency), and new bedding. The process to educate, support and supervise the team at Prospect House Shelter is well underway as they begin to embrace principles of trauma-informed and gender-responsive care for people who are homeless.

**Clinical Services:** RNP now offers gender-specific groups in each of its clinical programs. In addition, the agency has more than doubled the number of trauma specific groups offered throughout clinical services. Over forty staff have been

trained in TAG evidence-based curriculums and all supervisors have received 12 to 16 hours of training in clinical supervision. This training has been identified as integral to ensuring that staff are trained and supported, allowing them to respond to clients and families with compassion, empathy and respect while recognizing the short and long-term impact of trauma. Tremendous effort is placed on collaborative interventions, providing choice to clients as often as possible.

With a better understanding of issues related to trauma and gender, RNP has made significant changes in the manner that clinical assessments are conducted. Priority is placed on the individual's sense of safety by ensuring privacy and confidentiality. While successful efforts were made to reduce paperwork, an exception was made to include additional questions about trauma experiences to better assess and capture accurate information. RNP places great emphasis on forming therapeutic relationships built on principles of trust, collaboration, dignity and respect. Participation in TAG has strengthened this resolve and commitment.

**Accountability and Support:** The accountability and support built into the TAG Initiative remains essential to RNP's progress. Quarterly state-wide meetings facilitated by DMHAS and the CWC have proved to be a great resource. In these meetings, an open conversation about challenges, as well as sharing ideas and agency achievements, has been extremely valuable, resulting in a wonderful balance of support, honest feedback and accountability. The organizational assessment and technical assistance and support provided by the consulting experts, Stephanie Covington, Roger Fallot and Eileen Russo, have, likewise, proven to be invaluable both in managing the process and defining next steps.

**Next Steps and Sustainability:** RNP recognizes that providing trauma-informed and gender-responsive care is a long-term commitment and change process. There continues to be steadfast support for this work from each level of leadership, as well as an equally motivated and enthusiastic steering committee. A significant milestone directly related to sustainability included the promotion of one of RNP's TAG champions to RNP's Coordinator of Trauma and Gender Services. This new position will continue to work closely with RNP's Chief Clinical Officer and Steering Committee in not only sustaining progress made to date, but in continuing to lead us forward.

**On a final note:** in April of 2013, RNP was selected to speak at the annual meeting for the National Council for Behavioral Health on TAG Specific Implementation Strategies within a Behavioral Healthcare Organization. RNP received an honorary "Best in Class" award for its innovative work in this area, with the recognition that RNP has sixteen unique programs and many different levels of care. While we are humbled and honored to have received this recognition, our greatest hope is that this award will serve as inspiration to all who are committed to improving the trauma-informed and gender-responsive care of individuals under their care.

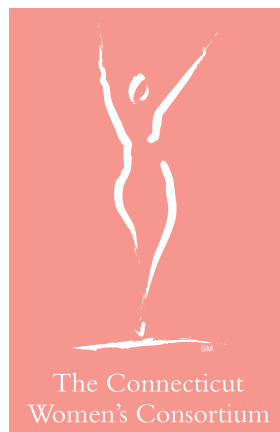
*Submitted by Jennifer Kolakowski, LCSW  
Chief Clinical Officer, RNP*

## OF NOTE: Dr. Jackson Katz, PhD to Speak on Gender Violence

Dr. Katz, PhD is internationally recognized for his groundbreaking work in gender violence prevention education in schools, the sports culture, and the military, as well as for his pioneering work in critical media literacy. Dr. Katz will be presenting a 1-day training on October 16<sup>th</sup>, 2014 sponsored by the CT Women's Consortium in collaboration with the Master of Social Work (MSW) Program of the Department of Social Work at Quinnipiac University entitled ***More Than a Few Good Men: American Manhood and Violence Against Women***. This training will introduce participants to a creative new way of conceptualizing the role of men in what historically have been considered "women's issues". With a combination of exercises and discussion, Katz will share a series of strategies for inspiring men to work in collaboration with women to change the social norms that tolerate sexist or abusive behaviors. **For more information or to register go to:** [www.womensconsortium.org](http://www.womensconsortium.org).

- 6 -

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