Trauma Matters

Special Edition : COVID-19

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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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Trauma-Informed Spaces in the Midst of a Pandemic

Emily Hoyle and Colette Anderson

The uncertainty and loss born from the coronavirus has led to widespread trauma and stress. Dr. Karestan Koenen, a trauma expert and professor of psychiatry epidemiology at Harvard T.H. Chan School of Public Health, recently remarked upon the trauma of the coronavirus, saying, "Uncertainty and lack of control are the two key drivers of stress. And we know that stress is related to increased anxiety and depression, particularly among people who are vulnerable."(1) In recognition of this unfolding and serious mental health crisis, organizational leaders—especially those who hope to uphold trauma-informed principles—should be motivated to account for the experiences of their staff and respond by updating their policies and practices to reflect new COVID-19-specific circumstances.

Prior to the explosion of the coronavirus pandemic in March, The Connecticut Women's Consortium proudly promoted trauma-informed principles both internally and among professional peers. Since transitioning to a work-from-home based model, The Consortium has doubled down on efforts to promote trauma-informed principles in order to minimize the traumatic experience of the coronavirus for staff, friends, family, and peers. Here, we reflect on The Consortium's transition in order to offer insights into the best ways to employ trauma-informed principles in the midst of a pandemic.

Trauma-informed care is defined by four key assumptions. The first is that the agencies, organizations, and systems that work through a trauma-informed lens realize the widespread impact of trauma. The second and third assumptions stipulate that those employing trauma-informed care seek to recognize symptoms of trauma in staff, clients, and others, and respond to their knowledge by fully integrating trauma understanding into their organization's policies. In doing so, the implementation of trauma-informed principles actively resists re-traumatization (2).

In a regular setting, leadership at The Consortium maintains trauma-informed standards through structured staff meetings, staff-scheduled activities such as yoga, retreats, and lunch and learns, encouragement of casual conversation, and opportunities for staff to learn new skills and work within new groups. These, in tandem with other activities, promote the core tenets of trauma-informed systems—safety, trust, empowerment, choice, and collaboration—within the office space. The goal when transitioning to a work-from-home setting is to foster these practices and the values they advance from afar as a method to promote staff resiliency. To do this, leadership must ensure that people are building trauma-informed coping tactics into their day-to-day routine and taking the time to break away from prolonged work stress and screen time.

In order to meet the standards of a trauma-informed workplace and to reflect the needs of the employees within that workplace, effective leadership should adopt responsive goals as defining traits of their work-from-home policies. The first priority on this list should be emotional self-regulation. It is crucial that organizational leadership support the emotional and mental wellbeing of their employees by making employees' ability to self-regulate a top concern. Resources like The Consortium's free mindfulness trainings, featured heavily on its website, play an integral role in providing the context and tools for individuals to cope with COVID-19 and work-related stress. Leaders should reframe employee behavior in the context of the pandemic

(Continued from page 1) and note that decisions and tendencies in this time are reflective of the stress that employees are currently facing. In that same vein, both professional and personal relationships become integral to stress response and mutual understanding.

In a recent statement, Maggie Young of Liberation Programs Inc. wrote about Liberation's experience with trauma-informed principles during the pandemic, stating, "We recognize that trustworthiness and collaboration is crucial for building and maintaining connections and clinical alignment, to that end we increased counseling which includes Zoom and FaceTime calls home to their identified family members/loved ones and we encourage family contact and family counseling through telehealth ensuring recoverees have an open choice to engage or not. With optional distant learning opportunities, women self-selected and engaged in support via the faith-based community, various support groups (NA/AA etc.) and assignments such as book club reading and journaling that they are passionate about." Here, it is evident that the leadership at Liberation Programs recognizes the role of relationships, trust, and choice, among other facets of trauma-informed work, in promoting overall group success and are therefore doubling down, not abandoning, these principles in light of a global crisis. Evidently, when it is even more difficult to maintain trauma-responsive policies, those policies become all the more important.

In addition to interpersonal relationships, it is important to consider the cultural and social context in which groups work. The reality of race and privilege in America is not something that can be ignored in a trauma-responsive workplace. Within trauma-informed spaces, it is important to give space for difficult and demanding conversations. As Maggie Young subsequently noted in the statement mentioned above, "When the spike in racial disparity was again at the forefront, we engaged with women by having uncomfortable conversations inclusive of topics related to past trauma, fears, and anxiety which are driven by race, police brutality, privilege and discrimination to name a few. We encouraged the women to ask questions, to continue to give themselves permission to feel and fear through their emotions as they arise, and to challenge themselves to use their voices where in the past they may have silenced themselves or were taught to be silent."

In a time when uncertainty is the underlying feeling, leaders who want to maintain a trauma-informed approach must be ready to have tough conversations and be honest with their employees regarding their company's status and obstacles. Only when leadership is transparent and in regular communication can clients, staff, and supervisors collaborate effectively despite the stress of the coronavirus.

As a practical reality, leadership at The Consortium has been able to uphold trauma-informed principles in roughly the same manner from home as they would from the office. Each week, staff members participate in check-ins, supervisions, team meetings, and a staff meeting to help foster collaboration and unity. Yoga sessions and mindfulness trainings have been moved online via streaming, and staff members are encouraged to take the opportunity to stretch and take care of themselves. Due to the strain on direct service providers, some of the trauma-responsive practices described here might be difficult to emulate. As The Consortium is unique among its behavioral health peers in not providing direct services, some key facets of trauma-responsive leadership have come more easily than they would in a direct-care environment. With that in mind, the core values of trauma-informed and responsive workplaces—as well as the things that make us resilient, such as community support, mental health regulation, communication, and trust—remain the same across the board.

Family Violence and COVID-19

Rebecca Beebe, PhD, Amy Hunter, MPH, PhD, Susie DiVietro, PhD

Intimate partner violence (IPV) and child abuse and neglect (CAN) are ubiquitous, often co-occurring traumas taking place every day in homes throughout the country. IPV is defined as patterns of behavior used by one partner in an intimate relationship to control the other. Notably, IPV affects one in three women and one in seven men in their lifetime (Black 2011). CAN includes sexual, physical or emotional abuse and various forms of neglect. Approximately 700,000 children in the U.S. are identified as victims of child maltreatment each year, and 16 percent experience multiple forms (U.S. Department of Health & Human Services, 2020). Given the similarities in victim and perpetrator risk factors, it is unsurprising that IPV and CAN co-occur. It is estimated that 10-20% of children are exposed to IPV in the home annually and up to 1/3 will be exposed at some point during their childhood or adolescence (Carlson 2000). While child exposure to IPV is not uniformly identified as a specific form of CAN, research demonstrates that such exposures put children at increased risk for a host of mental, behavioral, and physical (chronic and acute) health problems.

Social and physical distancing measures adopted in response to the coronavirus pandemic are exacerbating IPV and child maltreatment, making those who are vulnerable even more susceptible to violence. Measures taken to mitigate the spread of disease have inadvertently reduced the number of mandated reporters with eyes on children, and reduced access to support in the form of advocates or health professionals for victims of IPV. Additionally, the Black Lives Matter movement has highlighted something long known among IPV providers: The police do not always make things better for victims of IPV. Often victims themselves are arrested when the police arrive, extending the trauma and complications of IPV. While it is critical that the police take IPV and CAN seriously and respond appropriately, we must acknowledge that some communities, and particularly communities of color, see the risks of calling the police as too great. In addition to calling for reforms to police practice, we must also consider alternative supports.

For people who use violence, the pandemic presents new and increased opportunities for control, abuse, and access to victims. Stress attributed to the pandemic provides a unique alibi and rationalization for cultivating isolation within the home. Social isolation is a well-established strategy of people who use violence against an intimate partner, primarily because it is a very effective way to establish and maintain control. With an ally in the pandemic, offenders remove their victims from the eyes and ears of professional helpers, undermining decades of work done to get IPV and CAN out of the

home.

Health care providers recognize the long and short-term health consequences of IPV and CAN, and screening for both are considered essential to comprehensive care. Mandatory arrest policies and primary aggressor laws, as well as the Child Abuse Protection and Treatment Act (CAPTA), reflect the shift away from viewing these issues as private problems. Mandatory CAN reporting laws identified particular community members as protectors with a responsibility for the safety and well-being of children. With this, educators emerged as critical informants within child protection, comprising one-fifth of reporters annually.

The onset of COVID-19 has shifted this dynamic, highlighting and reinforcing social inequities. Outside of the classroom, educators' visual access to children has been limited by their school districts financial ability to implement chrome book programs that permit virtual classrooms. Even then, children living in poverty, or those whose families have been financially strained due to furloughs and mass layoffs, may not have the internet access to interact with teachers and classmates. Similarly, online resources for victims of IPV are largely unavailable to families without consistent internet access. This is compounded by the fact that victims of IPV often wait until they are alone to reach out for services, which is particularly challenging now.

Child welfare and our communities often prioritize reports from mandated reporters over non-mandated. In fact, non-professionals make up less than 20% of accepted reports (U.S. Department of Health & Human Services, 2020). However, informal networks of community members, neighbors and friends play a multi-layered role in protecting families and reducing IPV (Nixon et al. 2016). Social pressure and intolerance of violence, compared with a normalization of family violence, reduce IPV. Another layer includes neighbors and friends speaking up to ensure that people who use violence know that it is not condoned or endorsed in their community (Vioth 2019). As the people with the most proximity, neighbors are increasingly important in identification, reporting and providing a safe haven if needed.

Informal helpers have always played an important role in family violence prevention and intervention (Banyard et al. 2010). They are crucial now. Before COVID-19, we relied on educators because they saw our children regularly. Now it is our informal networks who are seeing children and adult victims of violence more regularly. It is critical that we cast a wider net of credibility to include these informal networks. A continuum of care that utilizes both informal (e.g. neighbors, clergy) and formal supports (e.g., counselors, health professionals), as well as collaboration between child welfare agencies and community-based IPV providers are essential to ensuring the safety and well-being of families.

Disaster planning has consistently omitted CAN from preparation considerations despite the awareness that disasters often bring increases in family violence. IPV service providers are rarely given increased funds in disaster budget planning, leaving already-overstretched organizations to face these crises and the spike in requests for services without needed surges in funds. In addition to making these legislative priorities, IPV and CAN should be promoted as public health issues that are everyone's responsibility. Like offering a ride to a friend who drank too much to drive, or a nurse reminding a colleague to wash their hands, innovative messages are needed to empower non-professionals to act.

Speaking out against family violence and promoting strategies for safety during this and future emergencies is something we can participate in together as communities. As professionals we need to support informal helpers, and as people, we need to be informal helpers.

National and local programs are available via call, text and web chat to provide support, safety planning or connecting to additional resources. For more assistance, call the Childhelp National Child Abuse Hotline, 1-800-422-4453, and the National Domestic Violence Hotline, 1-800-799-7233. If you or anyone you know is in need of immediate help, call 911. And please reach out to your friends, family members, and neighbors.

Ask the Experts:
A Survey of Connecticut Providers
Compiled by the Trauma Matters Board

Due to the unprecedented pressures of the coronavirus pandemic, the Trauma Matters Editorial board chose to combine several expert opinions as a survey response to key coronavirus issues. Responses from Family & Children's Agency's Chrissy Cacace, LCSW, Recovery Network of Programs, Inc.'s Jennifer Kolakowski, Clifford Beers' Dr. Yohanna Cifuentes, and Liberation Programs, Inc.'s Maggie Young, LADC, MSW.

How are you adapting your delivery of services during COVID-19 and what strategies do you think will be necessary as we move forward?

Maggie Young (MY): For individuals living with us they experienced increased stress when all visits were stopped with family/love ones including their children. We relied on FaceTime, Zoom etc. to maintain connections and contact. We also utilized telehealth for those in our care on an outpatient level in order to be respectful of sheltering in place and social distancing while maintaining support. Our medical team has also utilized curbside pickup and home delivery services for those quarantined or infected with COVID-19 to ensure they continue to receive MAT medications through the pandemic. To the greatest extent possible, we hope to be able to continue advances in telehealth for our Recoverees in OP, as well as with our medical partners for both OP and IP.

As we move forward, we need to further address disparities in care and outcomes related to chronic medical comorbidities and social determinants of health that exacerbate COVID-19 and many other health issues. Strategies include strengthening our partnerships with on-site primary medical care, enhancing care coordination, and increasing prevention efforts.

Chrissy Cacace (CC): We have primarily been using telehealth and continue to assess how to safely do in-person work. With such a wide range of programs, this takes a significant amount of planning (e.g. home visiting; after school programming; addiction treatment etc.). Beginning in July, some programs will begin to do visits with clients in the community (e.g. outside at a park; on a porch etc.) using proper PPE. We are working with the City of Norwalk as well as following state guidelines for returning back to the office but, at this point, because telehealth has been working so successfully, we do not plan to return to the office

before September 2020.

Dr. Yohanna Cifuentes (YC): Telehealth has worked successfully for a lot of clients who have high anxiety about leaving their homes due to COVID-19. Some clients do not feel comfortable with video and clinicians have used phone only sessions to still provide support. Objectives for treatment have changed for some clients to reflect their current needs.

Jennifer Kolakowski (JK): Within outpatient services, we have implemented telehealth services for individual, group and family services. It is essential that telehealth services continue as a choice for individuals with mental health and substance use disorders. There have been so many benefits to providing this additional choice and modality of treatment to clients.
Within medication assisted treatment we have been able to provide curbside dosing and home delivery for individuals who are medically compromised, frail and at high risk due to their age. This has been critical in protecting the health of our most vulnerable clients, while ensuring they receive their medication.
Within residential treatment, housing and detox, we have implemented creative solutions to engage and retain clients that include technology. This has been particularly helpful when individuals require self-isolation.
Within our emergency shelter services, we have worked collaboratively with other providers in providing overflow shelter and hotel accommodations to protect our residents and allow for self-isolation. This has required providing food service and staffing to two additional locations.

As a leader in your field, how have you encouraged your team or clients to approach self-care during COVID-19? What about self-care do you see as important during this time?

MY: Stay Home-Stay Safe has been the driving force for LPI, immediately upon the order to shelter at home, Self-care has been the topic of conversation and plans were set in motion for self-care inclusive of staggered shift, minimal staff on site and those who could, worked (s) remotely. In addition, we increased take home bottles for all of our MAT clients to ensure stress reduction related to potential lack of childcare and transportation barriers accessing services. We believe that it is imperative for one to engage in personal self-care in order to provide care to others. Because of the uncertainty and anxiety associated with experiencing the pandemic, we encourage increased contact with recoverees and daily check-in.

CC: My mantra – with myself and staff – has been "be gentle with yourself". No one has gone through this before and we're all doing the best we can. FCA has spent a lot of time in team meetings and supervision checking in on how people are doing. Some have adjusted to working remotely very well, others much less so. Our staff have had sick family members, live in small quarters, were navigating distance learning with their own children, dealt with economic ramifications or live alone and felt extremely isolated. Using supervision to check in has been helpful with keeping a pulse on this and ensure we are supporting staff. Additionally, our CEO continues to encourage staff to use their vacation time and take breaks so that we don't fall into the trap of working all the time just because our office is now where we live. FCA's CEO gave us an extra day off in May in support of this philosophy.

YC: As an agency, we provided 10 COVID-19 days and encouraged our staff to take time for self-care. From VP, Director, Manager, Clinicians- the message was clear and consistent- we were all working to adjust to a health crisis while attempting to work from home.

JK: In weekly communication, I have consistently acknowledged the additional stress and burden placed on staff and clients alike due to COVID-19. We have emphasized the need for self-care and have provided resources, reminders and inspiration to support staff in this area. While seemingly small in gesture, we have provided lunches for staff and also arranged a two day Gratitude Parade where the Executive Team and our HR Director travelled from program to program in parade like fashion, thanking all our staff with signs and letters of heartfelt expressed gratitude while delivering Pepe's Pizza.
Our HR Department has provided tremendous support to our staff during this time, encouraging flexibility for time off and utilizing EAP services and making themselves available 24 hours a day, seven days a week.

What work have you or your team accomplished during the pandemic that you are proud of and hope to continue down the road?

MY: LPI has maintained our workforce at full capacity; all programs including inpatient, have continued admissions and remained open with minimal interruptions because we are closely following CDC and state guidelines. In addition, our team is becoming experts related to remote work. We have spent countless hours ensuring operations through Zoom and Teams; this is something we will continue after the pandemic. We will keep in place the increased communications to our Recoverees, which included updates regarding services and resources at Liberation as well as in the community, and look for ways to help our Recoverees obtain access to technology.

CC: We have been able to strengthen our Social Justice work with a trauma informed lens, given all that is going on in our country. Again, providing space to process in team meetings as well as communication from Executive leadership has been critical. In fact, as of earlier this week, we are no longer celebrating Columbus Day as an Agency holiday but will honor Juneteenth with a day off to remember the tragedy of slavery and celebrate its abolishment. Much like the Agency putting up gender neutral restroom signs, to the people Juneteenth "matters to", this shift in holidays mattered a whole lot. I'm incredibly proud of FCA for this shift.

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YC: We transitioned exceptionally fast to providing telehealth services to our clients. Clinicians learned about telehealth and were provided training time to adjust and provide trauma informed care (as they adjusted to working from home and went through their own overwhelming feelings).

JK: I am in awe and so incredibly proud of how our team at RNP has come together during these difficult, chaotic times. Our employees and management team have taken RNP's values and made them visible each day. As a team, we completely reinvisioned the delivery of services to increase safety, support and care for both employees and clients. The dedication and commitment of our staff have ensured that every RNP program has remained open throughout the pandemic and in many cases have enhanced many aspects of care to better meet the needs of those we serve. In sharing resources and support with one another, staff have coined #PROUDTOBERNP. I could not be more proud of the dedication, commitment and compassion demonstrated by our RNP team.

Grief Amplified + Mourning Interrupted = Mourning COVID-19 Style

Debbie Pausig, LMFT, CT

Can you see me? Can you hear me? Can you touch me? The answers to these questions may be yes or a decisive no due to the widespread reaches of the COVID-19 pandemic. Today, we are collectively grieving and mourning in a way never before known in our lifetime. To recognize and understand this, we must first define grief and mourning during a disaster.

Grief is the constellation of internal thoughts and feelings we experience after a significant loss. Grief is what we feel on the inside. Mourning is the outward expression of our grief. This includes the expression of any traumatic thoughts and feelings we might have. (Alan Wolfelt, 2014)

The pandemic is widely recognizable. Officially, on March 13, 2020, President Trump declared: All 50 states, the District of Columbia, and 4 territories have been approved for major disaster declarations to assist with additional needs identified under the nationwide emergency declaration for COVID-19. Additionally, 32 tribes are working directly with FEMA under the emergency declaration. (FEMA.GOV, 2020)

GRIEF AMPLIFIED

Since the explosion of COVID-19 on the American public forefront, the sight, sound, and touch of grief has changed. Our sadness and sorrow, our anger, fear, and guilt are all normal emotions of grief. But, the sadness and sorrow we so often experience in uncomplicated, traditional grief is becoming a type of chronic sorrow intensified by the direct and indirect compounded losses brought forward by COVID-19. As a result, many are experiencing "grief overload", a series of losses in a short amount of time. Anger is normal during these times of heightened emotions. It is easier to be angry than sad and afraid. Guilt is common under anger.

The COVID-19 pandemic has us collectively experiencing an immense range of losses. To name a few: Loss of Health; Loss of Life; Loss of Job; Loss of Food Sources; Loss of Income; Loss of Assets; Loss of Security; Loss of Sense of Safety; Loss of Trust; Loss of Control; Loss of Spontaneity; Loss of Freedom; Loss of Choice; Loss of Predictability; Loss of a Lifestyle, Loss of Rites of Passage (school, proms, graduations) Loss of our Assumptive World; etc.

Perhaps we are grieving the "death" of many of the aforementioned. Merriam-webster.com illustrates one definition of death as the passing or destruction of something inanimate, another definition is extinction. In light of COVID-19, we are seeing the passing and perhaps extinction of a lifestyle we once knew.

Can you see me in life?

During the quarantine, your ability to see the people you live with is determined by their need to "self-quarantine" from exposure. If available, you can communicate with quarantined loved ones over a smartphone video app. Despite that, loved ones were separated for many weeks during hospitalization. Loved ones in nursing homes and assisted living facilities were unable to see their loved ones and quarantined in their rooms. One local family accessed a landscapers bucket truck to raise them to a nursing home's third floor window in order to "see" their elderly loved one as they held an "I Love You" sign only a week before that loved one died from COVID-19. In the midst of our disconnection, people over the age of 60, as well as those with health issues, have become an endangered species. We must stay away to lessen the risk of exposure. But it is not the same as seeing our loved ones and friends up close and personal.

MOURNING INTERRUPTED

Can you see me after death?

This too was a no. Memorial services and church services were prohibited and families had to forgo traditional death rituals. Early on families could not gather for a goodbye inside the funeral home. Families gathered in their respective cars, rode to the cemetery, and viewed the burial from their cars. There were no graveside gatherings. No one truly "saw" anyone. If they did, it was behind a new, homemade facemask. Even now, as limited gatherings, facemasks, and social distancing prevail, the ability to mourn as we once knew is gone. The pandemic and its limitations has become an interruption of a necessary intimate gathering of mourning souls.

Can you hear me?

We hear the wailing of personal and collective grief in voices. We even hear it muffled through the sea of facemasks. We experience the grief of not being able to tell a dying loved one "goodbye".

Can you touch me?

The inability to touch a loved one, hold hands or hug has been a huge loss during this time of quarantine and social distancing. The sick and dying are tended to by the loving and compassionate medical personnel clad in layers of PPE. Absent is the presence and skin to skin hand holding, face stroking, gentle kissing, and hugging. That kind of touch that says, "I am here", "I love you", "You are going to be okay", "We are going to be okay" and perhaps, "goodbye". These integral pieces of human connection have been lost between loved ones, friends, neighbors, the community and even friendly strangers during

(Continued on page 6).

Featured Resource:
Training and Technical Assistance Related to COVID-19

The Substance Abuse and Mental Health Service Administration (SAMHSA) has compiled a list of resources which provide training and technical assistance (TTA) on matters related to the mental and substance use disorder field as they deal with COVID-19 (https://www.samhsa.gov/ then click on the COVID-19 Guidance and Resources icon; scroll down to Training and Technical Assistance Related to COVID-19).

This resource (updated regularly) contains links to both upcoming live and recorded webinars, videos, tool kits, podcasts, print media (brochures, monographs, reports, posters) and presentation slides. The topics pertain both to staff self-care during the pandemic as well as working with clients during this period.

You may access this list of resource directly via:

https://www.samhsa.gov/sites/default/files/training-and-technical-assistance-covid19.pdf

Who's Been Reading Trauma Matters? Seth Wallace!

Pictured left to right is Eilieen Russo, Colette Anderson, Seth Wallace, and Kathleen Callahan.

Seth Wallace, Assistant Director at Yale University Office of LGBTQ Resources, joined our Trauma and Gender Learning Collaborative in February 2020, presenting on trauma in the LGBTQ community. Seth captivated the group with his energy and authenticity, sharing personal stories and challenging us to recognize our own beliefs and assumptions. Creating a safe space for all of us, Seth demonstrated the clinical importance of the core values of trauma-informed care – safety, trustworthiness, collaboration, choice, and empowerment; while reminding that building relationships by listening and asking questions to learn about those we serve are skills that turn interactions into therapeutic opportunities.

(Continued from page 5). illness, quarantine, self-distancing, and hospitalization.

Alan Wolfelt companioning philosophy helps us be present with the mourner and walk alongside them in this wilderness called grief. In time we will reconcile to this new way by learning to live with our grief and being forever changed.

MOURNING COVID-19 Style

How do we mourn as a family, as neighbors, as a community, as a nation and worldwide without the rituals that have been in place for as long as we know? How do we mourn when we cannot be together? We mourn with Love. We mourn "together" by any means possible. We are resilient people who have resources within us given by our creator and we have external resources. How do we mourn? We mourn COVID-19 Style, anyway we can think of: Caravan, distanced at the curb-side, Zoom, etc. until we slowly gather once again, in person, together again.

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