

NETWORK NEWS



The comprehensive resource on domestic violence

SPRING 2012

A PUBLICATION OF THE OHIO DOMESTIC VIOLENCE NETWORK

Spotlight on Trauma, Mental Health, and Substance Abuse

Traumatic experiences, such as domestic violence, impact individuals in multiple ways. As domestic violence programs and funders at the federal level are supporting a move towards trauma-informed services, it is important to have knowledge of the ways in which trauma impacts people's mental health and stability. Normal responses to experiencing ongoing traumatic stress include increased anxiety and arousal, feelings of depression and hopelessness, having thoughts or reminders of traumatic events overwhelm them, panic attacks, or a general disassociation and detachment with life. Emotional outbursts, fluctuating moods, anger, and irritability also are common responses to trauma. A domestic violence program should regularly expect to see all of these reactions when providing services to domestic violence survivors. In Ohio, domestic violence programs provide a wide variety of

services. Some domestic violence programs are licensed to provide mental health and/or substance abuse treatment. Yet all programs are working with women who are using substances, dealing with reactions to traumatic experiences, and have been diagnosed with mental health conditions. This newsletter is about providing information on how domestic violence impacts survivors and beginning conversations within your programs about effectively and compassionately serving survivors who are using substances, experiencing mental health symptoms, and are struggling to cope with the ways in which trauma has impacted them. See page 3 and page 5 for information on some fantastic, free, downloadable resources that can assist you with practical ways to work with survivors experiencing these difficulties. Links will also be available at www.odvn.org.

It's Not You - It's What Happened to You: Domestic Violence and Diagnosing Mental Health Disorders

By: Shayna L. Jackson, MSSA, LISW-S, Executive Director, WomenSafe, Inc.

The experience of living with an abuser impacts survivors of domestic violence in a multitude of different ways, including their mental health. For many abuse survivors, mental health symptoms abate with increased safety and social support, yet not for all victims. A wide variety of studies have shown that victimization by an abusive partner places women at significantly higher risk for depression, anxiety, post traumatic stress disorder, medical problems, substance abuse and suicide attempts, and have also shown that abuse victims generally report more unmet mental health needs (National Center on Domestic Violence & Mental Health, 2012). What this means is that many people we serve in domestic violence programs are labeled as having a mental health diagnosis.

For agencies that serve domestic violence survivors and also provide mental health services, this reality poses some specific challenges. Is the diagnosis that the person reports accurate? Should the domestic violence program report the diagnosis in the case record?

Let's take the example of a woman who enters into an emergency shelter and states that she has been diagnosed with depression. If we take that diagnosis as accurate without any further exploration, we might be missing some very important information about the reality of the survivor's life. There are a number of questions that come to mind that need to be addressed. How does that diagnosis impact how service providers

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perceive her? Does this mean that she is in need of medication? Is she suicidal? Can she care for her children? Will she be able to live with other women?

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) is the primary system used to classify and diagnose mental disorders. To be diagnosed with a major depressive disorder, a survivor would have had at least five of the symptoms listed below present in a two-week period of time to receive this diagnosis. Below are the criteria, followed by potential alternative explanations:

1. *Depressed mood most of the day, nearly every day.* Could the depressed mood be the result of having to live in an emotionally abusive home where she hears that she is fat, worthless, and a terrible mother every day?
2. *Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.* Could it be that she no longer shows pleasure in anything because every aspect of her life is controlled, scrutinized, and manipulated by another person?
3. *Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.* Could it be that her abusive partner controls what she eats, or that the survivor overeats as an attempt to cope with the abuse?
4. *Insomnia or hypersomnia nearly every day.* Could it be that she can no longer sleep because he wakes her up so many times in the middle of the night to berate her for any little thing that he wishes to? Or that she has a hard time falling asleep because she is feeling on edge all the time?
5. *Psychomotor agitation or retardation nearly every day.* Could it be that she is agitated because if she shows up late, he has promised to shoot their dog?
6. *Fatigue or loss of energy nearly every day.* Could it be that she is exhausted trying to constantly anticipate his next move?
7. *Feelings of worthlessness or excessive or inappropriate guilt nearly every day.* Could it be that she is told that she is worthless every day and after years of abuse and isolation, she feels like it is her fault?

8. *Diminished ability to think or concentrate, or indecisiveness, nearly every day.* Could it be that thinking about the potential negative consequences for every action or decision makes it unsafe or nearly impossible to make decisions or to even think for herself?
9. *Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.* Could it be that she feels like she is never going to be able to get free from her partner, and maybe is contemplating suicide as her only way out?

These are just a few examples of alternative explanations for symptoms of a common diagnosis of mental illness. With these alternative explanations, it would appear that she was not mentally ill, but that she was appropriately reacting to a situation that is out of her control. Thus, when women come to shelter and say that they have been diagnosed with a mental illness, it is important to conduct the assessment within the context of the trauma that the individual has experienced. In many cases, this may result in a very different (if any) diagnosis.

Although the above example illustrates a case where alternative explanations for depressive symptoms exist, there are cases where an individual does indeed have depression or some other type of mental illness. Traumatic experiences can often exacerbate the symptoms related to that mental illness. However, this diagnosis should not define who the person is, just as a medical diagnosis does not define a patient. A person does not say that someone is "canceric," but that she/he has been diagnosed with cancer. Unfortunately, people do say that someone is "schizophrenic." A mental illness is only one piece of a person's overall health and should be treated as such. In addition, many times people attribute all behaviors to that individual's mental illness when they may be better explained within the context of trauma. Thus, clinicians should assist a survivor in normalizing those behaviors rather than allowing a survivor to think that the problem is that her symptoms are not well-controlled. If you are not a clinician, it is still possible to help survivors normalize their reactions when you talk about the

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trauma and the possible impact that it can have on a survivor's behavior, emotions and mental health.

If a domestic violence program does not provide mental health treatment, the program will need to network with professionals in the area that are well versed in the topics of mental health, trauma, substance abuse, and domestic violence, as they all must be taken into account when treating a survivor. If this does not exist in a particular area, it is a great opportunity to work collaboratively with other agencies to develop a system of care that can accommodate survivors of domestic violence. This is especially true in cases where custody issues are being decided within the court system. Abusers will attempt to use a survivor's mental illness as a justification as to why they are an unfit parent. Without a clinician who can appropriately articulate the impact that the trauma of domestic violence has had on the survivor's current symptoms, it may be a difficult and uphill battle for the survivor to maintain custody of the children.

For those domestic violence programs that are providing mental health treatment, they are in a unique position that allows the clinicians to take all of these factors into account. In fact, the clinician has the responsibility to look holistically at the survivor and the way her experiences have impacted her. Clinicians should pay particular attention when survivors arrive with a diagnosis that has been given by another mental health professional. There are a number of clinicians who have not received appropriate training in trauma and may render a mental health diagnosis that may be inaccurate. The DSM-IV-TR is only as good as the clinician that uses it. In fact, the introduction of the manual states that it is designed to be used in conjunction with clinical judgment and not to be used in a "cookbook fashion." There is an evaluative and interpretive component that a clinician must do that is based upon one's area of expertise and competencies.

Each time we write down that someone has a mental illness, this label follows them even if the writer was not the person rendering the initial diagnosis. This diagnosis can have many

unintended and devastating consequences in the lives of survivors and their children, so it is of utmost importance that we carefully assess what to write down in files. Most agencies keep records for at least seven years before they are destroyed. In regards to children, these records may remain far longer than seven years. Clinicians should be cognizant of this fact as they work with clients in a mental health setting.



The National Center on Domestic Violence, Trauma & Mental Health

<http://www.nationalcenterdvtraumamh.org>

The National Center on Domestic Violence, Trauma & Mental Health offers materials and resources designed to support domestic violence programs in providing accessible, culturally relevant, and trauma-informed advocacy and services. The Center provides training, support, and consultation to advocates, mental health and substance abuse providers, legal professionals, and policymakers as they work to improve agency and systems-level responses to survivors and their children. The Center's work is survivor defined and rooted in principles of social justice.

Make sure to check out the multiple user-friendly resources under the "publications and products" section. This section contains dozens of downloadable, **free** resources for domestic violence programs. There is a Tip Sheet Series that provides guidance for advocates on things such as tips on creating a welcoming environment, enhancing emotional safety, supporting survivors with reduced energy, and connecting with survivors who have psychiatric disabilities. Each tip sheet is between 2-4 pages and provides good, concrete information on making services more trauma-informed. The Conversation Guide Series is designed to provide guidance to domestic violence programs working to build their own capacity to provide accessible, culturally relevant, and trauma-informed services. Each guide in the series will provide instructions on how to lead discussions and activities with program staff.



Spotlight on Local Programs

Art Therapy Program WomanSafe, Chardon, Ohio

The art therapy program at WomenSafe has been in place since 1992. Previously when a woman and her children entered the shelter, many of the services were directed toward helping women deal with feelings of guilt, shame, humiliation and fear about what has happened to them. The process of art therapy is another way to communicate what has happened to women as well as their children, while also building confidence. Art allows for choice making of subject and media and encourages experimentation, something that is usually not encouraged in a repressive family. The program has been especially helpful for children, who are natural artists. Children need stabilization after experiencing trauma. When they arrive they are given an art assessment which can help evaluate a child's present emotional and developmental state. Children may feel more comfortable drawing than talking about a fearful event. Drawing a picture about an event helps empower children by letting them be in control. Sometimes an overwhelming picture in their minds can be reduced in size and power when it is put on paper. Drawings can encourage narratives, and when a child's words are heard and validated, powerful emotions can become more manageable. Art is a great way to deal with stress.

Art supplies direct kinesthetic release. Examples are pounding clay, ripping paper (and then organizing it into a collage) and spattering paint. These activities are both therapeutic and fun.

Socialization

Children who come from abusive families are often isolated. Teaching social competence can help combat isolation and help children understand that they are not the only ones having these experiences. Respect for people and art materials can role model healthy interactions. Examples are sharing materials, taking turns, listening to others share drawings, using kind words to support one another and communicating clearly to say what you want. Joint projects such as mural making can foster cooperation.

Hand Print Mural

Children are asked to make their mark by placing their hand print on the wall. At this point they are assured that they are not alone, that many families have experienced abuse and that the child did not cause, nor can they fix the family problems. We can, however,

work together to make things better.

Through paint, clay, drawing and collage, survivors use these techniques to begin to find their voices. They discover through these activities that they are not alone and they begin to discover or regain their power.





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Mission Statement:

The Ohio Domestic Violence Network advances the principle that all people have the right to an oppression and violence free life; fosters changes in our economic, social and political systems and brings leadership, expertise and best practices to community programs.

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Free Trauma Resources

Trauma-Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs (2011)
by the Ohio Domestic Violence Network

Written by advocates for advocates, the manual provides an easy-to-understand explanation of trauma and the ways in which traumatic stress impacts a survivor's behaviors, thoughts, feelings, and actions. By understanding trauma as a normal response to an abnormal experience and learning effective ways to support survivors in their recovering from their trauma, we can further improve and enhance the services we provide and the care we offer. The manual outlines 16 best practices to incorporate into your organization, and also offers detailed protocols on providing trauma-informed domestic violence services such as answering hotline calls, doing intakes, facilitating support groups, and others.

Go to www.odvn.org. Under "resource center" click on "publications." Scroll down until you see the link to the trauma-informed care webinar and manual.

Getting Safe and Sober: Real Tools You Can Use: An Advocacy Teaching Kit for Working with Women Coping with Substance Abuse, Interpersonal Violence, and Trauma, Second Edition, (2008)
by the Alaska Network on Domestic Violence and Sexual Assault

This practical tool kit is for use with women experiencing trauma who have substance abuse or chemical dependence problems and who are, or have been, victims of domestic violence, sexual assault or sexual abuse. The kit also can be used to train service providers about the needs of women whose experience includes both substance abuse and victimization.

Real Tools: Responding to Multi-Abuse Trauma-A Tool Kit to Help Advocates and Community Partners Better Serve People with Disabilities, (2011)
by the Alaska Network on Domestic Violence and Sexual Assault

The primary goal of this tool kit is to help advocates and other service providers understand the safety, autonomy, recovery, wellness and justice needs of people who are impacted by multiple co-occurring issues. The manual is designed to go beyond theory to give advocates and their community partners practical tools to address those needs.

Go to www.andvsa.org. Click on "publications" and scroll down until you see these titles.

When Coping Becomes a Problem: Substance Use and Domestic Violence

By Tonia Moultry and Rachel Ramirez-Hammond

A part of providing trauma-informed services is being conscious to interpret all different types of behaviors we see in providing services through the lens of trauma. One of the ways in which we provide trauma-informed care is that instead of asking the question, “What’s wrong with you?” we ask, “What happened to you?” and understand the behaviors we see as ways in which people are attempting to cope with trauma and have been attempting to use different strategies to cope with stress and adapt to threats in the past.

For some domestic violence survivors who have been traumatized by an abusive partner, the use of substances in the form of drugs and/or alcohol can help relieve some of the distressing physical and emotional symptoms of trauma, such as feeling overly aroused or agitated, having intrusive thoughts about abuse that are upsetting, and feeling detached from the world around them. For those survivors who do have mental health illnesses, trauma can exacerbate mental health symptoms and can also lead to substance use as an attempt to manage symptoms that are extremely uncomfortable for survivors. Trauma also impacts such things as sleeping patterns, appetites, and generally feeling physically lousy. Using mood altering substances can often be interpreted as a coping mechanism that might have provided the survivor with some relief in times of abuse or stress. Sometimes, coping mechanisms that felt helpful at a point of time in our lives end up creating problems for us later, and substance abuse would be a key example of a coping mechanism that can easily get out of control.

Our job as domestic violence advocates is to support survivors with the issues that they struggle with, not to diagnose survivors with mental health disorders or to treat substance abuse or addiction. An important part of our advocacy is assisting survivors with understanding the ways in which abuse has impacted them and providing survivors with support and assistance in addressing coping mechanisms that the survivor identifies as no longer working for her. Because we all have our own opinions and understandings of substance abuse and addiction, it is critical that we are not using our own judgment on what to do about these coping strategies and instead

have clear, comprehensive agency policies in place to support the work of advocates and the physical and emotional safety needs of survivors.

The first step in screening survivors who have substance abuse issues is to identify and address your own attitudes and beliefs about substance abuse or addiction issues. To effectively screen, an advocate must be able to not only hear the survivor’s story but also be present. There are screening tools that have been developed and many advocates have been trained about the intersection of domestic violence and alcohol and drugs. Yet to effectively use that tool, it is not just a matter of asking the questions and checking off the correct boxes. The advocate has to be able and willing to engage the survivor in a conversation, which includes discussion on both the survivor’s and the abuser’s substance use and abuse. Knowing about the abuser’s substance abuse history will give the advocate a better idea of the tactics of coercive control that is used in the relationship, and will provide the advocate with important information to use in safety planning with the survivor. Knowing that you are working with a survivor whose partner uses substances to control them is important in many different ways, including what types of support the survivor needs, what concerns she has for her safety, and what referrals and assistance will be most helpful and relevant.

Shelters should strive to create an environment that is friendly and open to substance abusers.

Everyone deserves safety, regardless of their history of substance abuse. Yet many domestic violence programs have worked in both obvious and subtle ways to “screen out” those who use substances and attempt to keep addicts out of the shelter. Yet the connections between trauma, domestic violence, mental health symptoms and substance abuse are too strong for us to exclude these survivors from our services. By understanding substance abuse as a coping mechanism to address the impact of domestic violence on survivors, this means we should be expecting to see substance use when providing services and providing support in addressing it. By making our programs open and welcoming to all survivors, including those who are using substances

and experiencing mental health symptoms, this demonstrates to the survivors who seek our services that we care about who they are as a person and their addiction does not prevent them from receiving services to keep themselves and their children safe. To create this environment there are several steps that programs can take:

1. Adopt and enforce policies and procedures on how to screen all survivors who contact the program for residential services for the caller and the caller's partner's substance use. The policy should also speak to questions or conversational tips for advocates to use when speaking to any survivor who calls, as substance abuse may play a part in the violence.
2. Advocates should be trained as part of their initial 40 hours on the intersection between substance abuse and domestic violence. Advocates should attend additional trainings on substance abuse and domestic violence at least once every two years to stay current on new research and ways to support survivors and providing appropriate safety planning.
3. Have posters, brochures or literature displayed around the shelter that is supportive to recovery and speaks to the intersection between substance use and domestic violence.
4. Include recovery materials in your agency library. Examples would be the Alcoholics Anonymous book (The Big Book), meeting books, spiritual books and any other books that support recovery. (Contact your local substance abuse program for resources.) Do not include books on co-dependency, as this is not the behavior that survivors are displaying, although they may be told this repeatedly in treatment group and at Twelve Step meetings.
5. Survivors who are in recovery may want to give back. Possible options would be for them to act as sponsors for the women in shelter or that are receiving services.
6. If possible, have Twelve Step meetings for survivors only. This can be a meeting that is held at the shelter or in another location.
7. If you have not already done so, reach out and create a relationship with the local substance abuse treatment facility. Find out if referrals from the shelter can be assessed within 24 to 48 hours. Make sure to get a signed release so you can coordinate

efforts with the treatment facility to support the survivor. Also, find out if the facility offers gender specific groups. Women who are in gender specific groups have shown to do better than women in mixed gender groups.

8. Incorporate discussion on substance use and coping into support groups you do with survivors. Providing opportunities to talk about ways in which survivors have coped with violence in a non-blaming and open way provides a safe space for survivors to share. When a trauma survivor understands trauma symptoms and coping mechanisms as attempts to cope with intolerable circumstances, this understanding takes power away from abusers and an individual's abusive experiences.

As part of best practice, shelters should not exit survivors because they are using substances, but rather they should provide options and choices, including treatment and support. If a survivor who is using substances is exited from the shelter, where do you think she will go? This validates the abuser's statements that no one will help her, that she can only depend on him, and supports any other threatening statements that he has made to her. Survivors come to us for support. They should not have to choose between safety and sobriety.

For more information, check out the Alaska Network on Domestic Violence and Sexual Assault manual, "Getting Safe and Sober: Real Tools You Can Use" (2008) at www.andvsa.org.



Resilience and Thriving After Domestic Violence: How You Can Make a Difference

By Rebecca Cline and Rachel Ramirez-Hammond

At the recent National Conference on Health and Domestic Violence in San Francisco, California, participants learned that human beings are amazing organisms. We also experience terrible things that have terrible impacts on us. New data from the Centers for Disease Control and Prevention National Intimate Partner and Sexual Violence Survey (NISVS) measures the mental and physical health impact of abuse at the hands of a partner. Among findings were, “the percentage of women who considered their physical or mental health to be poor was almost three times higher among women with a history of violence compared to women who have not experienced ... violence” (Black, et.al. 2011). We learned about the Adverse Childhood Experiences (ACE) Study which link multiple childhood experiences such as witnessing domestic or community violence or growing up with a parent who was emotionally unavailable to negative health impacts as adults (Felitti, et.al., 1998). The negative impacts include obesity, drug and alcohol abuse, domestic and sexual violence and myriad other negative outcomes. Left alone with no intervention, these adverse childhood experiences are predictors for early adult death.

Yet we also learned about the many ways in which survivors resisted abuse and control. Through this resistance survivors developed and built new capacities, developed new skills, and discovered strengths and values in themselves that have enriched their lives. We have all worked with survivors who have managed to support a household, take care of their children, work, and do other incredible things in very difficult circumstances. Many of us have worked with survivors whose strength, courage, and determination has shown through in their quest for safety. We have learned that while traumatic stress impacts all of us, there is a tremendous opportunity and capacity for healing. We learned about neuroplasticity, which is the brain’s ability to reorganize itself by forming new connections between nerve cells in the brain throughout life. The brain *does* adapt and change in response to experiences and the environment, which means that children and adults regularly do recover and heal from their traumatic experiences of domestic violence. We learned about breakthrough new programs that seek to help young people and adults learn how to process their

experiences through the use of journal writing, art therapy, play therapy, and cognitive behavioral therapy, thereby reducing the negative impact of traumatic experiences.

What does this mean for those of us who work with and advocate for survivors of domestic violence? It means that we need to spend time with survivors helping them explore the multiple ways in which domestic violence impacted them and help them begin a healing process. We advocates may not have the training in cognitive behavioral therapy or art therapy, but there is a lot we can do. We know that healing from traumatic experiences occurs in the context of relationships, so we can help create a safe place for survivors to tell their stories and process through their traumatic experiences. We can be open and encouraging for survivors to share with us how they have coped with their experiences, even if those coping strategies have created problems or are hard for us to hear. We can share information about trauma and normalize reactions to trauma. This helps her understand how what has happened has changed her. We can establish a connection based on respect and focusing on strengths, and highlight some of the ways in which she has survived and fought against the oppression of abuse. It means we can help survivors by encouraging journaling about experiences which actually does lead to healing and improved health. We can encourage survivors to take care of themselves, to treasure themselves, and to develop strategies for physical, emotional, and mental well-being. We can help survivors by facilitating expression through art, play, and through talking about and processing their experiences.

So, what does this have to do with resilience? Resilience is defined as the ability to recover from or adjust to misfortune or change. Every day, women, children, and men experience domestic violence. Nearly every person who survives their experience with domestic violence has the innate capacity to heal from their trauma and to thrive. You can play an important role in laying that groundwork for recovery. Your work is a key to victims having access to becoming thrivers – not only survivors.

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ODVN Training Institute

For more information on trainings or to register, please go to www.odvn.org

Ready, Set, Go: Foundations of Prevention

When: May 23, 2012

Where: Columbus

Time: 9:30 a.m.-4:30 p.m.

Cost: \$60 (\$25 ODVN members)

CEUs: 5.5 Social Work/Counselor

Co-sponsored by the Ohio Alliance to End Sexual Violence (OAESV), this one-day training is designed to introduce the basics of primary prevention to new prevention specialists or prevention specialists who want a refresher on primary prevention. Participants will learn the Spectrum of Prevention model and gain insight concerning its application, explore prevention ethics, and explore primary prevention theory. Practical, hands-on application of concepts learned will be interwoven throughout the training based on participants' needs.

Alcohol, Drugs, and Domestic Violence

When: June 28, 2012

Where: Coshocton

Time: 9:30 a.m.-4:00 p.m.

Cost: \$60 (\$25 ODVN members)

CEU's: 5.5 Social work/Counselor

This training is designed to help advocates better understand the intersections of alcohol and other drugs (AOD) and domestic violence. Topics include the dynamics of alcohol and drug addiction, signs and symptoms of addiction, the treatment and recovery process, and how to recognize the impact of AOD use on survivors. The facilitator will discuss safety planning with addicted women or with women whose partners are addicted. Participants will gain awareness about community resources and how to effectively advocate for women with addiction issues.

"No hablo ingles": Working with Survivors of Domestic Violence with Limited English Proficiency

When: July 19, 2012

Where: Marion

Time: 9:30 a.m.-4:00 p.m.

Cost: \$60 (\$25 ODVN members)

CEUs: 5.5 Social work/Counselor

People of all ages, races, religions, and economic backgrounds look for the help provided by our agencies. This training will provide participants with an opportunity to learn about unique issues, barriers, and realities survivors with Limited English Proficiency (LEP) have. You will learn about Title VI of the Civil Rights Act of 1964, which prohibits recipients of federal funds from discriminating against individuals on the basis of national origin. You will have the opportunity to think of ways to make your organization more accessible and open to LEP individuals, find information on resources for underserved populations, learn about working with and accessing interpreters, and discover and creative ways to advocate with LEP survivors of domestic violence.

2012 Abilities Caucus Teleconference Series

When: June 13, August 8, October 10, December 12

Where: On your phone

Time: All teleconferences will be from 1:00 p.m.-2:30 p.m.

Cost: Free

Join us for this free series on barriers faced by survivors with different types of disabilities and how to effectively advocate and safety plan around unique challenges. Topics include developmental and cognitive disabilities, Deaf/hard of hearing, blind/visually impaired, and traumatic brain injury.

If you would like to make a tax deductible donation to Ohio Domestic Violence Network, please visit our website and click on the "Donate" button or mail a check to the address below. If you would like to become a member of ODVN, visit our Membership page on the website or send in the form below with a check. If you have any questions, contact Becky Mason at 614-781-9651, Ext. 221 or by email at rebeccam@odvn.org.

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Ohio Domestic Violence Network

4807 Evanswood Drive, Suite 201

Columbus, OH 43229

Phone: 614-781-9651 (Voice and TTY)

1-800-934-9840 (Voice and TTY)

Fax: 614-781-9652

Email: info@odvn.org

Website: www.odvn.org

CHECK IT OUT!

From ODVN's Resource Center

Materials from ODVN's Resource Center may be borrowed for free by ODVN members and Ohio residents. For more information or to borrow resources from our clearinghouse, please contact Tana Carpenter, 1-800-934-9840, Ext. 224.

Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror

When *Trauma and Recovery* was first published in 1992, it was hailed as a groundbreaking work. In the intervening years, Herman's volume has changed the way we think about and treat traumatic events and trauma victims. In a new afterword, Herman chronicles the incredible response the book has elicited and explains how the issues surrounding the topic have shifted within the clinical community and the culture at large. *Trauma and Recovery* brings a new level of understanding to a set of problems usually considered individually. Herman draws on her own cutting-edge research in domestic violence as well as on the vast literature of combat veterans and victims of political terror, to show the parallels between private terrors such as rape and public traumas such as terrorism. The book puts individual experience in a broader political frame, arguing that psychological trauma can be understood only in a social context. Meticulously documented and frequently using the victims' own words as well as those from classic literary works and prison diaries, *Trauma and Recovery* is a powerful work that will continue to profoundly impact our thinking.

Author: Judith Herman, M.D.

Format: Paperback

Length: 247 Pages

Year Produced: 1997

Beyond Labels: Working with Abuse Survivors with Mental Illness Symptoms or Substance Abuse Issues

This manual provides information, tools and resources for domestic violence and rape crisis center staff to better understand the connection between mental health and trauma. Readers will be better able to work with survivors experiencing mental health and substance abuse issues and how to create a center more welcoming to these survivors.

Author: Dianne King Akers, M.Ed., Michelle "Shell" Schwartz, M.A., and Wendie H. Abramson, LMSW

Publisher: SafePlace

Format: Paperback

Length: 228 Pages

Year Produced: 2007

Working with Women Survivors of Trauma and Abuse

Featuring Laura S. Brown, this DVD presents a treatment approach for working with women survivors of trauma and abuse and shows how to create a safe environment, teach self-care, and help clients process and integrate trauma. It considers the distinct way in which women process traumatic or abusive events.

Publisher: Insight Media {www.insight-media.com}

Format: DVD

Length: 100:00 Minutes

Year Produced: 2005

The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms

In *The PTSD Workbook*, two psychologists and trauma experts gather together techniques and interventions used by PTSD experts from around the world to offer trauma survivors the most effective tools available to conquer their most distressing trauma-related symptoms. Readers learn how to determine the type of trauma they experienced, identify their symptoms, and learn the most effective strategies they can use to overcome them.

Author: Mary Beth Williams, Ph.D., LCSW, CTS and Soili Poijula, Ph.D.

Format: Paperback

Length: 229 Pages

Year Produced: 2002

First Impressions...Exposure to Violence and A Child's Developing Brain

Designed for parents, this easy-to-understand video illustrates the dangers of chronic exposure to violence on a child's developing brain. Combining inspirational true-life stories and nationally recognized experts, parents are given the latest information on a child's developmental risks if regularly exposed to domestic violence and other violent situations.

Publisher: California Attorney General's Office and Iron Mountain Films

Format: On-line Video

Go to www.ironmountainfilms.com/?p=373 to view.

Length: 14:00 Minutes

Year Produced: 2008

Domestic Violence: Intersectionality and Culturally Competent Practice

Experts working with twelve unique groups of domestic abuse survivors provide the latest research on their populations and use a case study approach to demonstrate culturally sensitive intervention strategies. Chapters focus on African Americans, Native Americans, Latinas, Asian and Pacific Island communities, persons with disabilities, immigrants and refugees, women in later life, LGBT survivors, and military families. They address domestic violence in rural environments and among teens, as well as the role of religion in shaping attitudes and behavior.

Author: Edited by Lettie L. Lockhart and Fran S. Danis

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Department of Health & Human Services

PUBLIC POLICY UPDATE

By Nancy Neylon, Executive Director

Ohio

HB 116 Bullying (Representative Barnes)

Passed and Signed by the Governor

Effective Date: May 4, 2012; anti-bullying provisions effective November 4, 2012

The legislation, entitled the “Jessica Logan Act,” requires age appropriate anti-bullying education, if state or federal funds are appropriated, training of school personnel, annual issuance and notification to parents of policies prohibiting harassment, intimidation or bullying, expands the definition to include cyberbullying, and covers incidents on school buses.

Federal

Violence Against Women Act Reauthorization

The Violence Against Women Act, first authorized in 1994, creates and supports comprehensive, effective and cost-saving responses to domestic violence, dating violence, sexual assault and stalking. VAWA expired in December 2011 and must be reauthorized by Congress to ensure the continuation of lifesaving programs. We thank Senator Sherrod Brown for his co-sponsorship of S. 1925 and his continued support of this vital legislation.

S. 1925 as reported by the Senate Judiciary Committee represents the VAWA reauthorization legislation that is widely supported. S. 1925 was carefully crafted with new provisions based on interviews with more than 2000 law enforcement, court personnel, prosecutors, legal services, state and federal grant administrators and advocates from across the country. Twenty-two issue committees were convened to work through the responses and prioritize the most important issues still facing victims, including a lack of available services to LGBTQ victims, barriers to services for undocumented victims, and continuing high levels of violence against Native American and Native Alaskan victims. The Senate legislation was drafted in consultation with federal agencies charged with implementing the provisions of VAWA. The resulting legislation, S.1925 built on the past successes of VAWA, decreased the total amount of federal authorization levels by 20% and streamlined 10 programs into three.

Other versions of VAWA and amendments offered fail victims in a number of ways, including massive reduction in authorization levels, thus ensuring funding cuts, the elimination of protections for Native American and immigrant battered women, and creating new bureaucracies and inefficiencies that would divert already scarce funding.

The House of Representatives has not yet introduced VAWA Reauthorization legislation. It is expected to be introduced in the House in early June.

Voting in the Senate should have already occurred by the time this newsletter reaches you. For updated information on the outcome of VAWA in the Senate and progress in the House, check the ODVN web site or our Facebook page.

Resilience and Thriving After Domestic Violence

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OHIO DOMESTIC VIOLENCE NETWORK
4807 Evanswood Drive, Suite 201
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Financial Tip from our Finance Director *Amy Smith*

Dirty Dozen Tax Scams

Recently, the IRS released their annual list of “Dirty Dozen” tax scams. Making the list at number 10 is abuse of Charitable Organizations and Deductions. Two problems the IRS is keeping an eye on are: 1) individuals who donate in-kind items such as furniture or artwork and who overvalue those items when reporting them on their return; and 2) people who temporarily donate money to organizations to shield the money from getting taxed.

Nonprofit organizations should take care to ensure that they do not serve as a willing participant by allowing or setting up scenarios that allow its donors to misuse tax-exempt organizations and shield income or assets as a result.

The Ohio Association of Non-Profit Organizations has an educational packet, “Disclose It: A Charitable Nonprofits’ Guide to Disclosure Requirements” that discusses how you can ensure that your organization is in the best position to comply with fundraising laws and regulations. For more information, visit their website at www.oano.org or call them at 614-280-0233.